Health Plan Enrollment or Change
for New York State Individual Plans

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Termination** *Please complete all pages of this form.*

Section 1: Information About Yourself *(please include Applicant Name on page 2)*

Applicant Name *(First, Middle Initial, Last)*

Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code

County | Home Phone No. ( ) | Mobile Phone No. ( )

Email

Are you and/or your spouse eligible for Medicare? ☐ **Yes** ☐ **No**

If ***Yes***, provide your Medicare Member ID No(s). (Yourself) (Spouse, if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates

(Yourself) Part A Part B (Spouse) Part A Part B

Section 2: Enrollment/Change/Termination Information

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependent ☐ Name Change

☐ Transfer to Another Plan ☐ Address Change

Requested Effective Date

Reason *(explain)*

☐ Qualifying Event *(explain)*

☐ Other

Termination

☐ Terminate from Plan

☐ Remove Dependent(s) only *(specify name or member ID no.)*

Requested Effective Date

Reason for Termination

☐ Moved from Service Area ☐ Opting for Other Coverage

☐ Other

Section 3: Choose Your Coverage (Enrollments and Changes)

Medical Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Select One Medical Plan:

☐ Standard *Plan Name*

☐ Non-Standard *Plan Name*

Optional Medical Rider Selection

☐ Dependent through Age 29

☐ Unlimited Skilled Nursing

Optional Vision Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Vision coverage must be equal to or less than medical coverage.

Optional Vision Plan (select one) ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

Section 4: Pediatric Dental Coverage

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NY State of Health™ Marketplace-certified, stand-alone dental plan offered outside of NY State of Health Marketplace for every person listed in Section 5 of this application, as required by the Affordable Care Act? ☒ **Yes** ☐ **No**

If ***Yes***, please provide the name of the company issuing the stand-alone dental coverage.

MetLife

If ***No***, MVP will provide you coverage of the pediatric dental essential health benefit *(select one)*, as required by the Affordable Care Act.

☐ MVP Dental for Kids® ☐ MVP Dental PPO® for Families ☐ Delta Pediatric Dental PPO

If scanning this form for submission, be sure to scan and return all pages of this form.

Continued on page 2

Applicant Name

Section 5: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

You (Subscriber/Applicant) and each individual listed below must designate a choice of Primary Care Physician (PCP). To search for doctors in our network, visit **mvphealthcare.com/findadoctor** or contact the MVP Small Business & Individual Service Unit at **1-844-865-0250** for assistance.

Please use a separate form for additional individuals.

1 Applicant ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Are you already a patient of this physician? ☐ Yes ☐ No | PCP No.

2 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Spouse ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

3 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

4 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

5 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

Section 6: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

I hereby apply for membership in MVP. I hereby consent to the release, use, and disclosure of any medical information about me and any members of my family for whom I can give consent:

- By my primary care provider, any other health care provider, or the New York State Department of Health ("NYSDOH") to MVP and any health care providers involved in caring for me or my family, as reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations functions, or other functions permitted by, and in accordance with, applicable laws, regulations, and rules. This may include pharmacy and other medical claims information needed to help manage my care;
- By MVP and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administering health programs to the extent permitted by, and in accordance with, applicable laws, regulations, and rules; and
- By MVP to my providers or other persons or organizations, as reasonably necessary for MVP or my providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

Continued on page 3

Applicant Name

*(**Section 6: Authorization** continued from page 2)*

At any time, I can take away the permission I gave to release information. All I have to do is call the MVP Customer Care Center at the phone number listed on the back of my MVP Member ID card.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

☐ Yes ☐ No

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the state value of the claim for each violation.

I have read and agree to this authorization.

Signature *Date*

Section 7: Broker Information *(Complete if a broker assisted with completing this application)*

Broker Name	Broker Email	Phone Number
Laura Graff	lgraff@ahrensfinancial.com	( )

Agency Name	Agency Address	MVP Agency No.
Monroe County Bar Emp Trust	300 Corporate Pkwy, Amherst NY 14226	Group 413728

Section 8: Private Exchange Information

If you are enrolling via a private exchange (not through the NY State of Health Marketplace), provide the name of the private exchange.