NEW YORK SMALL GROUP ENROLLMENT/CHANGE FORM

ACTION REQUESTED:
☐ **Enroll**
☐ **Change**
☐ **Cancel**

NEW YORK
625 State St. PO Box 2207
Schenectady, NY 12301-2207
518-370-4793 or 1-800-777-4793

TO BE COMPLETED BY EMPLOYER	Group #	Subgroup #	Effective Date	Product ID #	Product ID #
Employee Class	Employee Dept. (if applicable)		Approved by		

1. INFORMATION ABOUT YOURSELF

INSTRUCTIONS TO EMPLOYEE: Please print or type and complete Sections 1 through 5.

Employee Name *(First, MI, Last)* Marital Status ☐ Single ☐ Married

Address City State Zip County

Phone Email Address Employer

Do you or any other family members have health insurance? ☐ Yes ☐ No If yes, by whom? Spouse's health insurance carrier *(if other than yours)* Spouse's health insurance ID#

Coverage level ☐ Subscriber ☐ Subscriber & Spouse ☐ Subscriber & Dependents ☐ Family

Eligible for Medicare? ☐ Yes ☐ No Member ID# Spouse/Dependent ID#

Member ☐ A Effective Date ☐ B Effective Date Spouse ☐ A Effective Date ☐ B Effective Date

2. ENROLLMENT/CHANGE

A. ☐ New Applicant ☐ Add Dependent ☐ Name Change ☐ Plan Transfer ☐ COBRA ☐ Address Change

REASON: ☐ New Hire ☐ Open Enrollment ☐ COBRA/State Continuation ☐ Qualifying Event *(describe)* _____ ☐ Other_____

Effective Date of Change_____

B. ☐ Termination ☐ Remove Dependent(s) only *(please specify)*_____

REASON:
☐ Termination of Employment ☐ Opting for Other Coverage
☐ Moved From Area ☐ Other_____

Effective Date of Change_____

3. CHOOSE COVERAGE

☐ Standard ☐ Non-Standard ☐ Metal Level _____ Metal # (if applicable)_____ ☐ Dental ☐ Healthy NY*

*You and each of your dependents must designate your choice of Primary Care Physician. For help, visit MVP's website **www.mvphealthcare.com** or contact the MVP Customer Care Center.

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York Health State of Health-certified stand-alone dental plan offered outside the New York State of Health? ☐ Yes ☐ No

B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.

4. INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

For additional dependents, please list on a separate form.

1. Self

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ – ___ ___ – ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

2. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ – ___ ___ – ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

3. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ – ___ ___ – ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

4. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ – ___ ___ – ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* PCP Number

Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

5. SIGNATURE

I have read and agree to the authorization of the reverse side of this form. **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 stated value of the claim for each such violation.**

_____ DATE _____

6. AUTHORIZATION

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP.

I hereby consent to the release of any medical, health and/or payment information (including without limitation pharmacy and claims information) about me and my minor eligible dependents by any licensed physician, hospital, other health care provider, or authorized federal, state or local agencies to MVP and any health care providers involved in caring for me or my minor eligible dependents, as reasonably necessary to allow MVP to administer my benefits or for MVP or my health care providers to carry out treatment, payment, or health care operations functions, to the extent permitted by law. I also agree that the information released for treatment, payment and health care operations may include HIV, STD, mental health or alcohol and substance abuse information about me and my minor eligible dependents to the extent permitted by law, until I revoke this consent.

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

By including an email address on this Enrollment/Change Form, you agree to accept electronic communication unless otherwise required by law.