



NEW YORK SMALL GROUP ENROLLMENT/CHANGE FORM

ACTION REQUESTED: NEW YORK

- Enroll
- Change
- Cancel

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 _____

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

Effective Date of Change _____

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

REASON: Termination of Employment Moved From Area Opting for Other Coverage 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)** ____ - ____ - ____ PCP Number _____

Primary Care Physician (PCP) *(First, Last)* _____

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)** ____ - ____ - ____ PCP Number _____

Primary Care Physician (PCP) *(First, Last)* _____

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)** ____ - ____ - ____ PCP Number _____

Primary Care Physician (PCP) *(First, Last)* _____

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)** ____ - ____ - ____ PCP Number _____

Primary Care Physician (PCP) *(First, Last)* _____

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.