



HEADQUARTERS
625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207
518/370-4793 1-800/777-4793

LOCAL MARKETING OFFICE:

To reach your local office, call 1-800-TALK-MVP and you will be directed to the appropriate marketing office.

MVP Health Plan, Inc.
MVP Health Insurance Company
MVP Health Services Corp.

Enrollment/Change Form

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

1 PLEASE PROVIDE US WITH INFORMATION ABOUT YOURSELF

Employee Name (Last, First, Initial, Suffix) _____ Sex M F
 Address _____ City _____ State _____ Zip _____ County _____
 Home Phone _____ Business Phone _____ Email Address _____
 Employer _____
 Employer Address _____ City _____ State _____ Zip _____
 Date Employed _____ Full Time Part Time Retired
 Marital Status Single Married Widowed Separated
 Is your spouse employed? Yes No If yes, by whom? _____
 Spouse's health insurance carrier (if other than yours) _____
 Spouse has Individual Coverage Family Coverage Spouse's health insurance ID# _____
 Eligible for Employee ID# _____ Spouse ID# _____
 Medicare? Employee A Effective Date _____ B Effective Date _____ Spouse A Effective Date _____ B Effective Date _____

2 PLEASE INDICATE ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call 1-888-687-6277

A New Applicant
 Name Change
 COBRA/State Continuation
 Add Dependent
Reason:
 New Hire
 Open Enrollment
 COBRA/State Continuation Qualifying Event (please describe) _____

B Termination
 Remove Dependent(s) only (please specify) _____
Reason:
 Termination of Employment
 Moved From Area
 Opting for Other Coverage
 Other _____

3 PLEASE CHOOSE YOUR COVERAGE

HMO* PPO Indemnity Dental
 POS* EPO Healthy NY* Prescription Drug Only
*Please choose a Primary Care Physician—for each family member—in Section 4.

4 PLEASE PROVIDE IMPORTANT INFORMATION FOR ALL FAMILY MEMBERS

If you are applying for HMO, POS or Healthy NY coverage, you and each of your dependents must designate your choice of Primary Care Physician in order for MVP to initiate coverage.

Relationship to Employee	Name First, MI, Last	Date of Birth MM/DD/YY	Social Security Number	Check if Student Over 18	Check if Disabled	Primary Care Physician (PCP) Last and First Name	PCP Number	Check Box if Current Patient
Self <input type="checkbox"/> M <input type="checkbox"/> F		/ /	/ /					<input type="checkbox"/>
<input type="checkbox"/> Spouse		/ /	/ /					<input type="checkbox"/>
		/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
		/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
		/ /	/ /	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

NOTE: With the exception of your spouse, each dependent must be under 19 years of age, unless a rider has been purchased to extend coverage, and a student or disability waiver is attached if necessary. To obtain a waiver, call MVP.

5 PLEASE SIGN (Employee, spouse, and all dependents 18 years of age or older must sign.)

I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

Employee's Signature x _____ Date _____
 Spouse's Signature x _____ Date _____
 Dependent's Signature x _____ Date _____
 Dependent's Signature x _____ Date _____

6 TO BE COMPLETED BY EMPLOYER

Group # _____
 Subgroup # _____
 Effective Date _____
 Product # _____
 Product # _____
 Employee Class _____
 Employee Dept. (if applicable) _____
 Approved by _____