



CHAMBER OF COMMERCE/PROFESSIONAL ASSOCIATION/MULTI-EMPLOYER GROUPS
Enrollment Application/Change Form

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

ACTION REQUESTED: Enroll
 Change
 Cancel

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

Employee Name (Last, First, Initial, Suffix) _____ Marital Status Single Married

Address _____ City _____ State _____ Zip _____ County _____

Phone _____ Chamber/Association Name _____ Date Employed _____ Active Retiree

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) _____ Coverage level Individual Family Spouse's health insurance ID# _____

Eligible for Medicare? Yes No Employee ID# _____ Spouse ID# _____

Employee A Effective Date _____ B Effective Date _____ Spouse A Effective Date _____ B Effective Date _____

2 ENROLLMENT/CHANGE For address or Primary Care Physician changes, call 1-800-318-8575 or visit www.mvphealthcare.com.

A Effective Date _____

New Applicant **Reason:**

Name Change New Hire

COBRA Open Enrollment

Add Dependent COBRA/State Continuation

Plan Change to _____ Qualifying Event (describe) _____

Address Change Dependent to 30 _____

B Effective Date _____

Termination

Remove Dependent(s) only (please specify) _____

Reason:

Termination of Employment Opting for Other Coverage

Moved From Area Other _____

3 CHOOSE COVERAGE

HMO* Product ID # _____

PPO

EPO

HDHP/HSA

HDHP

Dental

*Please choose a Primary Care Physician for each family member—in Section 4.

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

1. Name (First, MI, Last) _____ Relationship to Employee self

Male Female Date of Birth ____/____/____ Social Security No. (required) _____

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

2. Name (First, MI, Last) _____ Relationship to Employee spouse/civil union partner Domestic Partner

Male Female Date of Birth ____/____/____ Social Security No. (required) _____

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

3. Name (First, MI, Last) _____ Relationship to Employee _____ Check all that apply: Disabled Current Patient Full-time Student over 18

Male Female Date of Birth ____/____/____ Social Security No. (required) _____ If applicable: College Name _____

Primary Care Physician (PCP) (First, Last) _____ PCP Number _____ Expected Graduation Date _____

4. Name (First, MI, Last) _____ Relationship to Employee _____ Check all that apply: Disabled Current Patient Full-time Student over 18

Male Female Date of Birth ____/____/____ Social Security No. (required) _____ If applicable: College Name _____

Primary Care Physician (PCP) (First, Last) _____ PCP Number _____ Expected Graduation Date _____

For additional dependents, please list on a separate form.

5 PREVIOUS INSURANCE INFORMATION

	SUBSCRIBER	DEPENDENT	DEPENDENT	DEPENDENT
Effective Date of Previous Coverage				
Termination Date				
Carrier's Name				
Is Member Eligible for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you or any of your dependents been covered by another health plan during the last 63 days (excluding any waiting periods)? Yes No

Please note, that a "No" answer means that expenses resulting from any conditions for which care was received or recommended during the last six months (excluding employer waiting period) will not be covered until you have completed a twelve (12) month waiting period. If you had prior coverage which terminated within 63 days of your effective date (excluding employer waiting period), your prior coverage may be eligible to satisfy all or part of your twelve (12) month waiting period. Please complete the Previous Insurance Information section above and attach certificate of creditable coverage issued by your former insurer.

6 MUST BE COMPLETED IN FULL BY EMPLOYER AND ASSOCIATION

Employer Name	Group # 700161	Effective Date	<input type="checkbox"/> Sole Proprietor OR <input type="checkbox"/> Employer Group (Groups of 2 or more)
# of Employees (required)	Tax ID Number (required)		
When did employee become eligible for coverage (N/A for retiree)?	New Employer? (required) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer Signature	Date of Signature		
Is applicant currently working at least 20 hrs/week? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A for retiree <i>Subscriber, including sole proprietor, must be employed a minimum of 20 hours per week in order to qualify for benefits under this contract.</i>			
Association/Chamber Verification	ROCHESTER BUSINESS ALLIANCE		
Signature	Date		

7 AUTHORIZATION AND AGREEMENT

I have read and agree to the authorization below.

SIGNATURE _____ DATE _____

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, in New York, shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under my plan may be subject to preexisting condition limitations. If applicable, a medical questionnaire will be forwarded to you for your completion. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month (6) period ending on the enrollment date. We will exclude coverage for health care services during the first twelve (12) months of this Contract that relate to pre-existing conditions.

We will credit to the Covered Person the time he was covered under previous health insurance plans, if the previous coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date of this Contract.

Additionally, no pre-existing condition exclusion will be imposed on an "eligible individual" as defined in section 2741(b) of the federal Public Health Service Act, 42 USC §300gg-41(b).

I authorize my employer to deduct from my earnings the necessary contribution, if any, required of me.

I hereby authorize any licensed physician, hospital or other health care provider to furnish MVP with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow MVP to administer my benefits. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.

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