Dental Plan Enrollment or Change
for New York Individuals

MVP HEALTH CARE

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Termination**

Please complete both sides of this form.

Section 1: Information About Yourself *(please include Applicant Name and Group No. on page 2)*

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

Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code | County

Email | Phone ( )

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

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

Group No.

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependent ☐ Name Change
☐ Transfer to Another Plan ☐ Address Change

Requested Effective Date

Reason

☐ Qualifying Event *(explain)*

☐ Other

Termination

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

Requested Effective Date

Reason for Termination

☐ Opting for Other Coverage ☐ Moved from Service Area
☐ Other

Section 3: Choose Your Coverage (Enrollments and Changes)

☐ MVP Dental for Kids® ☐ MVP Dental PPO® for Adults ☐ MVP Dental PPO® for Families ☐ Delta Dental PPO Pediatric Basic Plan

Need help selecting a dental plan? Visit **mvphealthcare.com** or call **1-844-865-0250** to speak with an MVP Representative.

Section 4: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

Please use a separate form for additional individuals.

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

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

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

Continued on page 2

Applicant Name | *Group No.*

***(Section 4** continued from page 1)*

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

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

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

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

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

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

Section 5: 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, 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.

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.

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

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 a 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 6: Broker Information *(Complete if a broker assisted with completing this application)*

Broker Name | Broker Email | Phone Number ( )

Agency Name | Agency Address | MVP Agency No.

Questions? We're here to help. Call **1-844-865-0250** Or visit **mvphealthcare.com**

Return this completed application by mail to: **MVP HEALTH CARE 625 STATE ST PO BOX 2207 SCHENECTADY NY 12301-2207**