Health Plan Enrollment or Change Request

For Vermont Individual Direct Plans

Instructions for Completing this Request

Please complete all sections of this Request form and return all pages to MVP Health Care® by mail to:
MVP HEALTH CARE, 625 STATE ST, SCHENECTADY NY 12305-2111.

If you have questions or need help with this Request form, call **1-844-865-0250** or visit **mvphealthcare.com**.

1. Which of the following best describes your employment status currently?

☐ **Employed for the full year or a portion of the year** ☐ **Not employed** *(Skip to Question 5)*

2. What best describes the size of your employer, if employed?

☐ **Under 50 employees** ☐ **50+ employees**

3. Will you receive funds from your employer to pay for *your* health premiums and/or medical bills? This does not include funds for a spouse or domestic partner.

☐ **No** *(Skip to Question 5)* ☐ **Yes**

4. How will you use these funds?

☐ **Pay for premiums** ☐ **Pay for medical bills** ☐ **Pay for both premiums and medical bills**

☐ **I will not use any of these funds**

5. Do you currently have a spouse/domestic partner?

☐ **No** *(Proceed to Page 2)* ☐ **Yes**

6. Will your spouse/domestic partner receive funds from their employer to pay for your health premiums and/or medical bills? If your spouse/domestic partner is not employed, choose "no."

☐ **No** *(Proceed to Page 2)* ☐ **Yes**

7. How will you use these funds from your spouse/domestic partner's employer?

☐ **Pay for premiums** ☐ **Pay for medical bills** ☐ **Pay for both premiums and medical bills**

☐ **I will not use any funds from my spouse/domestic partner's employer**

(Continue to Page 2)

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

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For Vermont Individual Direct Plans

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

Please complete all pages of this form.

Section 1: Information About Yourself *(please print)*

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

Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code

County | Home Phone No. ( ) | Mobile Phone No. ( )

Email

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

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependent ☐ Address Change

☐ Name Change ☐ Transfer to Another Plan

Requested Effective Date

Reason *(explain)*

☐ Qualifying Event

☐ Other

Note: Effective dates are based on date of receipt at MVP.

Termination

☐ Terminate from Plan

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

Requested Effective Date

Reason for Termination

☐ Moved from Service Area ☐ Opting for Other Coverage

☐ Other

Section 3: Choose Your Coverage (Enrollments and Changes)

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

☐ **Standard** ☐ **Non-Standard** ☐ **Medical Plan Name** *(e.g. Gold 4 HDHP)*

Optional Vision Coverage Level ☐ **Applicant** ☐ **Applicant and Spouse** ☐ **Applicant and Dependent(s)** ☐ **Family**

Vision coverage must be equal to or less than medical coverage.

Optional Vision Plan (select one) ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

If scanning this form for submission, be sure to scan and return all pages of this form.

Continued on page 2

Applicant Name

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 ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

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

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

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

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

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

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

Section 5: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

Note: Vermont residents who do not receive Advanced Premium Tax Credit (APTC) or Vermont Premium Assistance (VPA) from the State of Vermont are able to purchase an Individual plan directly through MVP Heath Care. You can determine if you are eligible for these subsidies by visiting **VermontHealthConnect.gov** and selecting *Try Our Decision Tools*, or visiting **mvphealthcare.com** and using the *Subsidy Calculator*. If you are eligible, and want to enroll utilizing a subsidy (APTC or VPA), you will need to enroll through the Vermont Health Connect website. If you are not eligible, or eligible but choose to enroll without using any APTC or VPA subsidies, you can enroll directly with MVP Health Care.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. By submitting this enrollment form and personal information, I confirm that I am the policy holder and authorized to make this decision. I understand that if I enroll directly with MVP, I give up my rights to any tax credits or subsidies. I authorize MVP to submit a cancellation to Vermont Health Connect for any On-Exchange coverage I may be enrolled in through Vermont Health Connect.

Only plans purchased through Vermont Health Connect are eligible for subsidies from the government including advanced premium tax credits (APTC) or cost-sharing reductions (CSR). I understand that I am enrolling in a plan that is ***not*** eligible for APTC, CSR, or any financial assistance from the government. I understand that the subsidy calculation at **mvphealthcare.com** is an estimation and not an official determination of eligibility and that it is my responsibility to confirm my official eligibility for subsidies on the Vermont Health Connect website.

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 applicable Vermont regulatory agency 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 applicable Vermont regulatory agency 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.

I also agree that the information released for treatment, payment, and health care operations may include information about me concerning HIV and/or mental health, to the extent permitted by applicable laws, until I revoke this consent.

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.

Continued on page 3

Applicant Name

*(**Section 5: Authorization** continued from page 2)*

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

☐ Yes ☐ No

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 may also be subject to a civil penalty.

I have read and agree to this authorization.

Signature Date

Questions? We're here to help. Call **1-844-865-0250** Or visit **mvphealthcare.com** Fax: **518-386-7595**

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