Enrollment or Change Request

For New York State Student Health Plan Student and Their Dependent(s)

Instructions for Completing this Request

Return this completed Request by mail to: **MVP Health Care, PO Box 2207, Schenectady NY 12301-2207**.

If you have questions or need help completing this Request, call **1-800-TALK-MVP** (1-800-825-5687) or visit **mvphealthcare.com**.

Reason for Request *(select one)*: ☐ Enrollment ☐ Change ☐ Termination

Section 1: School Information *(This Section to be completed by the School)*

School Name	Group No.

Effective Date	Approved By

Section 2: Information About Yourself *(Please include Student Applicant Name at top of page 2)*

Student Applicant Name	Student ID No.	Date of Birth	Marital Status ☐ Single ☐ Married

Street Address	City	State	Zip Code	County

Phone No.	Mobile Phone No.	Email

Section 3: Enrollment/Change/Termination Information

Enrollment or Changes

- ☐ **New Student Applicant—Open Enrollment Period**
- ☐ **New Student Applicant—Non-Open Enrollment Period** *
- ☐ **Add Spouse or Dependent(s) to Existing Plan** *
- ☐ **Name Change** *(You do not need to complete Sections 4 and 5)*
- ☐ **Address Change** *(You do not need to complete Sections 4 and 5)*

** Requires Qualifying Event, provide explanation below)*

Requested Effective Date of Enrollment/Change

Qualifying Event Explanation

Termination

- ☐ **Terminate from Plan**
- ☐ **Remove Spouse/Dependent(s) Only**
  (Provide the name(s) or MVP Member ID Nos. below)

Requested Effective Date of Termination

Reason for Termination

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

(You do not need to complete Sections 4 and 5 for Terminations)

Section 4: Coverage Selection—Enrollment and Changes Only

Medical Coverage Level *(select one)*

☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependents ☐ Family

Medical Plan Name *(e.g., Gold 2 HDHP)*

Continued on page 2

Student Applicant Name

Section 5: Information About All Family Members to be Enrolled in Your Plan *(* Required)*

If you are adding a Spouse or Dependent(s) to an existing plan, only provide the information for those new family members below. Use a separate form for additional dependents.

Student Applicant ☐ **Male** ☐ **Female** ☐ **Non-Binary**	Age	Date of Birth *	Social Security No. *
Primary Care Physician (PCP) Name		MVP PCP No.	Already a patient of this PCP? ☐ **Yes** ☐ **No**
Spouse Name ☐ **Male** ☐ **Female** ☐ **Non-Binary**	Age	Date of Birth *	Social Security No. *
Primary Care Physician (PCP) Name		MVP PCP No.	Already a patient of this PCP? ☐ **Yes** ☐ **No**
Dependent Name ☐ **Male** ☐ **Female** ☐ **Non-Binary**	Age	Date of Birth *	Social Security No. *
Primary Care Physician (PCP) Name		MVP PCP No.	Already a patient of this PCP? ☐ **Yes** ☐ **No**
Dependent Name ☐ **Male** ☐ **Female** ☐ **Non-Binary**	Age	Date of Birth *	Social Security No. *
Primary Care Physician (PCP) Name		MVP PCP No.	Already a patient of this PCP? ☐ **Yes** ☐ **No**

Section 6: Authorization *(Applicant's signature is required for all Enrollments, Changes, or Terminations)*

I hereby apply for membership in MVP Health Care ("MVP") and 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.

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).

I have read and agree to this authorization. By including my signature below, I certify that the information provided in this Request is true and complete to the best of my knowledge and belief.

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 state value of the claim for each violation.

Applicant's Signature *Signature Date*