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

LOCAL MARKETING OFFICE:
1 Club Acre Lane, Bedford, NH 03110
603/647-7181

MVP Health Plan of New Hampshire, Inc.
MVP Health Insurance Company
of New Hampshire, Inc.

New Hampshire Enrollment/ Change Form

INSTRUCTIONS TO EMPLOYEE: Please print or type and complete Sections 1 through 5 and 8

1 Please provide us with information about yourself

Employee Name *(Last, First, Initial, Suffix)* _____

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 ☐ Domestic Partner ☐ Widowed ☐ Separated

Is your Spouse or Domestic Partner employed? ☐ Yes ☐ No If yes, by whom? _____

Spouse or Domestic Partner's health insurance carrier (if other than yours) _____

Spouse or Domestic Partner has ☐ Individual Coverage ☐ Family Coverage Effective Date _____

Spouse or Domestic Partner's health insurance or policy ID # _____

Eligible for Medicare? ☐ Yes ☐ No

Employee ID# _____ Spouse or Domestic Partner ID# _____

Employee ☐ A Effective Date _____ ☐ B Effective Date _____ ☐ D Effective Date _____

Spouse or Domestic Partner ☐ A Effective Date _____ ☐ B Effective Date _____ ☐ D 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 ☐ POS* ☐ EPO

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

4 Please provide the following information for all family members you want enrolled under your plan

If you are applying for HMO or POS coverage, you and each of your dependents must designate your choice of Primary Care Physician. For help, please visit MVP's Web site www.mvphealthcare.com or contact the MVP Member Services Department at 1-888-MVP-MBRS (1-888-687-6277).

Relationship to Employee	Gender	Name First, MI, Last	Date of Birth MM/DD/YY	Social Security Number	Check if Student Over 19	Check if Disabled	Primary Care Physician (PCP) Last and First Name	PCP Number	Check Box if Current Patient
Self	☐ M ☐ F		/ /	/ /					☐
☐ Spouse or Domestic Partner	☐ M ☐ F		/ /	/ /					☐
	☐ M ☐ F		/ /	/ /	☐	☐			☐
	☐ M ☐ F		/ /	/ /	☐	☐			☐
	☐ M ☐ F		/ /	/ /	☐	☐			☐
	☐ M ☐ F		/ /	/ /	☐	☐			☐
	☐ M ☐ F		/ /	/ /	☐	☐			☐

NOTE: With the exception of your spouse or domestic partner, each dependent must be under 19 years of age, or a full time student under age 25 who has submitted a completed College Student Waiver Form, or an Adult Disabled Dependent who has submitted a completed Disability Waiver Form. You may download these forms from MVP's Web site, www.mvphealthcare.com or contact the MVP Member Services Department at 1-888-MVP-MBRS (1-888-687-6277) to request the forms.

CONTINUED ON BACK

5 Other coverage information

1. Indicate plans in force during the last 9 months. Please provide Certificates of Creditable Coverage.

2. Do you, your spouse or domestic partner or any named dependent already have existing health coverage with another company? ☐ Yes ☐ No If yes, please complete the questions below.

Policy Holder of other Health Coverage _____

Policy Holder's Relationship to your Dependent's _____ Policy Holder's Month and Day of Birth _____

Is this insurance Family court ordered? ☐ Yes ☐ No ☐ N/A If Yes, please attach a copy of that section of the court order which pertains to health insurance coverage and complete the questions below.

Do you have physical custody of your dependent(s)? ☐ Yes ☐ No OR Is there joint legal custody? ☐ Yes ☐ No

Where does your dependent(s) reside? ☐ Mother ☐ Father

6 Authorization

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under MVP's plans may be subject to preexisting condition limitations.

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.

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

7 Agreements

I, the undersigned, agree that all answers in the application: (a) are true and complete to the best of my knowledge and belief and (b) will be relied on to determine insurability and (c) which are incorrect for misleading, may void the application effective the issue date.

No Agent/Producer can: (a) waive or change any receipt; or (b) agree to issue a Certificate of Coverage. I have: (a) read the Agreements section and (b) read and approved the answers as recorded.

8 Please sign (Employee, spouse or domestic partner, and all dependents 18 years of age or older must sign.)

I HAVE READ AND AGREE TO THE AUTHORIZATION AND AGREEMENTS ABOVE.

Employee's Signature x _____ **Date** _____

Spouse or Domestic Partner's Signature x _____ **Date** _____

Dependent's Signature x _____ **Date** _____

Dependent's Signature x _____ **Date** _____

Dependent's Signature x _____ **Date** _____

Dependent's Signature x _____ **Date** _____

Dependent's Signature x _____ **Date** _____

9 To be completed by employer

Group # _____

Subgroup # _____

Effective Date _____

Product # _____

Product # _____

Employee Class _____

Employee Dept. (if applicable) _____

Approved by _____