

Self-Insured Health Plan Enrollment or Change

For Plan Offered by Your Employer and Administered by MVP Select Care, Inc.



Action Requested: Enrollment Change Termination

Please complete all three pages of this form.

To be Completed by Employer (please include the Group Name and Number on page 2)

Group Name BRICKLAYERS AND AC LOCAL 5		Group No. 248290	Subgroup No.	Effective Date
Product ID No.	Product ID No.	Employee Class	Employee Dept. (if applicable)	Approved By

Section 1: Information About Yourself (please print)

Applicant Name (First, Middle Initial, Last)			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Street Address		City	State	Zip Code
County	Home Phone		Mobile Phone	
Email Address				
Employer			Date Employed <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Do you or any family members have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, with whom? (Name of Carrier)		
Spouse's Health Insurance Carrier (if different than yours)			Spouse's Health Insurance ID No. (if carrier is different than yours)	

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

Are you and/or your spouse eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Name Change
 Transfer to Another Plan Address Change COBRA

Requested Effective Date _____

Reason

- New Hire (Date of Hire: _____) Open Enrollment
 COBRA/State Continuation
 Qualifying Event (explain)
 Other

Termination

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

Requested Effective Date _____

Reason for Termination

- Termination of Employment Opting for Other Coverage
 Moved from Service Area
 Other

Group Name	Group No.	Employee Name
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Section 3: Choose Your Coverage (Enrollments and Changes)

HMO
 PPO
 Indemnity
 POS
 EPO
 HDHP EPO
 HDHP PPO
 Dental
 Vision
 Prescription Drug Only

HMO Health Maintenance Organization plan
 PPO Preferred Provider Organization plan
 POS Point of Service plan
 EPO Exclusive Provider Organization plan
 HDHP High-Deductible Health Plan

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
 Social Security No. *(required)*

Primary Care Physician* *(First, Last)*
 Are you already a patient of this physician?
 PCP No.
 Yes
 No

2 Name *(First, Middle Initial, Last)*
 Relationship to Applicant
 Spouse/Civil Union Partner
 Domestic Partner
 Dependent

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

Primary Care Physician* *(First, Last)*
 Already a patient of this physician?
 PCP No.
 Yes
 No

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

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

Primary Care Physician* *(First, Last)*
 Already a patient of this physician?
 PCP No.
 Yes
 No

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

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

Primary Care Physician* *(First, Last)*
 Already a patient of this physician?
 PCP No.
 Yes
 No

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

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

Primary Care Physician* *(First, Last)*
 Already a patient of this physician?
 PCP No.
 Yes
 No

* For HMO and POS plan applicants, you (Applicant) and each individual listed below must designate a choice of Primary Care Physician (PCP). To search for doctors in our network, visit mvphealthcare.com/findadoctor, or contact the MVP Customer Care Center at **1-888-687-6277** for assistance.

Group Name	Group No.	Employee Name
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Section 5: Authorization (Your signature is required for Enrollments, Changes, or Terminations)

On behalf of myself and any members of my family for whom I have enrollment authority and have listed on this enrollment form, I (we) 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 or my family, 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.

I also understand and agree that the information released for treatment, payment, and health care operations may include information about HIV, mental health, alcohol and substance abuse, or a disability about me and members of my family to the extent permitted by, and in accordance with, applicable law, regulations, and rules, until I revoke this consent. It may also be information needed to see if someone qualifies for disability services.

At any time, I can take away the permission I gave to release information. All I have to do is call MVP.

I hereby certify that the statements made are 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 **mvphhealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP’s Electronic Disclosure, which is available at **mvphhealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

I have read and agree to this authorization.

Signature

Date

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

MVP SELECT CARE, INC 625 STATE ST PO BOX 2207 SCHENECTADY NY 12301-2207 1-800-229-5851

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.