



VERMONT OFFICE

Enrollment/Change Form

ACTION REQUESTED:
 Enroll
 Change
 Cancel

TO BE COMPLETED BY EMPLOYER Group # _____ Subgroup # _____ Effective Date _____ Product ID Number _____
 Employee Class _____ Employee Dept. (if applicable) _____ Approved by _____

1 INFORMATION ABOUT YOURSELF

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

Employee Name (Last, First, Initial, Suffix) _____ City _____ State _____ Zip _____ County _____
 Address _____ Phone _____ Employer _____ Date Employed _____ Coverage Individual Family Spouse's health insurance ID# _____
 Do you or any other family members have health insurance? Yes If yes, by whom? _____ Spouse's health insurance ID# _____
 Eligible for Medicare? Yes No Employee ID# _____ Spouse ID# _____ Spouse A Effective Date _____ B Effective Date _____
 Employee A Effective Date _____ B Effective Date _____ Active Retiree

2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call 1-800-318-8575 or visit www.mvphealthcare.com.

A Reason:
 New Applicant New Hire Termination
 Name Change Open Enrollment Remove Dependent(s) only (please specify) _____
 COBRA COBRA/State Continuation **B** **CHOOSE COVERAGE**
 Add Dependent Qualifying Event (describe) _____ HMO* PPO Prescription Drug Only TriVantage (choose an option):
 Plan Transfer Address Change Other _____ Indemnity (ViiP) High Deductible HMO Family Focus
 Other _____ Termination of Employment Opting for Other Coverage Dental High Deductible EPO Healthy Alternatives
 Moved From Area Other _____ POS* High Deductible PPO

Effective Date of Change _____ Effective Date of Change _____ *Please choose a Primary Care Physician—for each family member—in Section 4.
 If you are applying for HMO or POS coverage, you and each of your dependents must designate your choice of Primary Care Physician.

4 INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

Relationship to Employee **self**

1. Name (First, MI, Last) _____ Social Security No. (required) _____ PCP Number _____
 Male Female Date of Birth ____/____/____ Relationship to Employee _____ PCP Number _____
 Primary Care Physician (PCP) (First, Last) _____

2. Name (First, MI, Last) _____ Social Security No. (required) _____ PCP Number _____
 Male Female Date of Birth ____/____/____ Relationship to Employee _____ PCP Number _____
 Primary Care Physician (PCP) (First, Last) _____

3. Name (First, MI, Last) _____ Social Security No. (required) _____ PCP Number _____
 Male Female Date of Birth ____/____/____ Relationship to Employee _____ PCP Number _____
 Primary Care Physician (PCP) (First, Last) _____
 Eligible for insurance through own employer? Yes No Employer _____

4. Name (First, MI, Last) _____ Social Security No. (required) _____ PCP Number _____
 Male Female Date of Birth ____/____/____ Relationship to Employee _____ PCP Number _____
 Primary Care Physician (PCP) (First, Last) _____
 Eligible for insurance through own employer? Yes No Employer _____

Check all that apply: Disabled Current Patient Full-time Student over 18*
 If applicable: College Name _____ Expected Graduation Date _____

Check all that apply: Disabled Current Patient Full-time Student over 18*
 If applicable: College Name _____ Expected Graduation Date _____

Late entrant? Yes No For additional dependents, please list on a separate form.

5 SIGNATURE

I have read and agree to the authorization of the reverse side of this form. SIGNATURE _____ DATE _____

*Applicable to HMO products only. This information will be used to determine eligibility for student out-of-area coverage.

MVP COMMERCIAL ENROLL FORM (2/11)

AUTHORIZATION

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 may be a crime and, may also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided by Vermont Non-Group Indemnity Plan (Viip) may be subject to pre-existing condition limitations except for those under age nineteen (19).

I authorize my employer to deduct from my earnings the necessary contribution, if any, required of me.

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. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC, and further precludes the insurer from forwarding new HIV testing information except as specifically permitted under 8VSA §4724(20) and Department Bulletin I-92.

The statements made are true and complete to the best of my knowledge and belief.