625 State Street, PO Box 2207
Schenectady, NY 12301-2207
mvphealthcare.com

DATE: ______________________________

SUBSCRIBER NAME: ______________________________

SUBSCRIBER ADDRESS: ______________________________

CITY: ______________________ **STATE:** ________ **ZIP CODE:** __________

MEMBER ID: ______________________________

DISABLED DEPENDENT NAME: ______________________________

In order for your dependent to continue coverage under your plan, please complete the following information below marked, **"TO BE COMPLETED BY THE SUBSCRIBER."** The member's Primary Care Physician should complete the separate form marked, **"DISABILITY ELIGIBILITY DETERMINATION FORM—**to be completed by Primary Care Physician" (also available on MVP's website). Please return the information to MVP Health Care, PO Box 2207, Schenectady, NY 12301, Attn: Enrollment & Eligibility within 30 days or your dependent may be disenrolled from your policy. Once all the necessary information is received, your request for continued coverage will be reviewed.

If you have any questions, please call the Customer Care Center number on the back of your member ID card.

TO BE COMPLETED BY THE SUBSCRIBER

1. Does your dependent receive social security income for this disability? ☐ Yes ☐ No
2. Does your dependent have other insurance coverage, such as Medicare or Medicaid, for this disability? ☐ Yes ☐ No
3. Is/was your dependent employed? ☐ Yes ☐ No If yes, number of hours per week. ________
4. Name of Primary Care Physician: ______________________________

   Address of Primary Care Physician: ______________________________

   Phone Number of Primary Care Physician: (______) ______________________________

We look forward to continuing to help you take on life and live well.