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

MVP ViiP (Vermont Individual Indemnity Plan) Enrollment/Change Form

INSTRUCTIONS: Please print or type and complete Sections 1 – 9

1 PLEASE PROVIDE US WITH INFORMATION ABOUT YOURSELF

Applicant Name *(Last, First, Initial, Suffix)* ______ Sex ☐ M ☐ F

Address ______ City ______ State ______ Zip ______ County ______

Mailing Address for Premium Notices *(if different from above)* ______ City ______ State ______ Zip ______ County ______

Social Security # ______ Home Phone ______ Business Phone ______ Email Address ______

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated Spouse's health insurance ID# ______

Eligible for Medicare? Applicant ID# ______ Spouse ID# ______

Please provide Certificates of Creditable Coverage or other means of proof. Other means of proof which may be submitted include explanation of benefits, correspondence from the plan indicating coverage, pay stubs showing a payroll deduction for health coverage or a health insurance identification card.

Applicant ☐ A Effective Date ______ ☐ B Effective Date ______ Spouse ☐ A Effective Date ______ ☐ B Effective Date ______

2 PLEASE INDICATE ENROLLMENT/CHANGE For address changes, call 1-888-687-6277

A ☐ New Applicant ☐ Name Change ☐ Add Dependent

Reason: ______

B ☐ Termination ☐ Remove Dependent(s) only (please specify) ______

Reason: ☐ Moved From Area ☐ Opting for Other Coverage ☐ Other ______

3 PLEASE CHOOSE YOUR DEDUCTIBLE AND PREFERRED EFFECTIVE DATE

Deductible: ☐ $3,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $100,000 Requested Effective Date of Coverage (Month/Day/Year) ______

Your coverage will be effective on the first day of the month you choose.

4 PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

Relationship to Applicant	Name First, MI, Last	Date of Birth MM/DD/YY	Social Security Number	Check if Student Over 18	Check if Disabled
Self ☐ M ☐ F		/ /	/ /		
☐ Spouse		/ /	/ /		
		/ /	/ /	☐	☐
		/ /	/ /	☐	☐
		/ /	/ /	☐	☐

NOTE: With the exception of your spouse, each dependent must be under 19 years of age, or a full-time student under age 25, or have a disability waiver – attached if necessary. **To obtain a waiver, call MVP.**

5 PRE-EXISTING CONDITION INFORMATION

1. During the past 12 months, has any person proposed for insurance ever received medical care for or had (check all that apply):

☐ Kidney Disorder ☐ Cancer ☐ Heart Disease ☐ Alcoholism
☐ Liver Disorder ☐ Stroke ☐ Diabetes ☐ Nervous Disorder
☐ Digestive Disorder ☐ Back Disorder ☐ High Blood Pressure ☐ Arthritis
☐ Tumor ☐ Anemia ☐ Prostate Disorder ☐ Respiratory Disorder
☐ **None of these**

2. During the past 12 months, have you been treated or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician? ☐ Yes ☐ No

3. During the past 12 months, other than shown in #1 above, has any person proposed for insurance (check all that apply):

☐ Sought or been advised to seek treatment for any illness or injury
☐ Had surgery ☐ Had a medical examination or medical care
☐ Been hospitalized ☐ **None of these**

4. Are you or any person in your immediate family pregnant? ☐ Yes ☐ No
If "Yes", give anticipated delivery date ______________________and
Doctor's name ______________________

5. Complete the following to expand upon all affirmative answers above.

Name ______________________Condition(s) ______________________
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Name ______________________Condition(s) ______________________
Name ______________________Condition(s) ______________________
Name ______________________Condition(s) ______________________

6 OTHER COVERAGE INFORMATION

Do you, your spouse or any named dependent already have or are applying for hospital, disability, major medical, HMO or dental coverage with another company? ☐ Yes ☐ No

Indicate Plans in Force During the Last 12 Months. Please provide Certificates of Creditable Coverage or other means of proof. Other means of proof which may be submitted include explanation of benefits, correspondence from the plan indicating coverage, pay stubs showing a payroll deduction for health coverage or a health insurance identification card.

Type of Coverage: ☐ Major Med ☐ Major Hosp ☐ HMO ☐ Disability ☐ Dental ☐ Medicaid ☐ CHAMPUS/TRICARE ☐ Child Health Plus Name ______________________
Company or Association and Address ______________________Policy Certificate #______________Issue Date ____________Paid To-Date __________
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc.______________________

Type of Coverage: ☐ Major Med ☐ Major Hosp ☐ HMO ☐ Disability ☐ Dental ☐ Medicaid ☐ CHAMPUS/TRICARE ☐ Child Health Plus Name ______________________
Company or Association and Address ______________________Policy Certificate #______________Issue Date ____________Paid To-Date __________
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc.______________________

Type of Coverage: ☐ Major Med ☐ Major Hosp ☐ HMO ☐ Disability ☐ Dental ☐ Medicaid ☐ CHAMPUS/TRICARE ☐ Child Health Plus Name ______________________
Company or Association and Address ______________________Policy Certificate #______________Issue Date ____________Paid To-Date __________
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc.______________________

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Company or Association and Address ______________________Policy Certificate #______________Issue Date ____________Paid To-Date __________
List Deductible, Maximum Amount, Elimination Period, Benefits, Benefit Period, etc.______________________

7 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 Healthy NY, HMO, Indemnity, PPO, and EPO 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. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.

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

9 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 Subscriber Contract. I have: (a) read the Agreements section and (b) read and approved the answers as recorded.

8 SIGNATURES

Signature of Applicant______________________
Signature of Spouse (If a Proposed Dependent) ______________________

I/We certify that during an in-person interview with the Proposed Insured(s), I/We asked each question exactly as written and recorded the answers provided by the Proposed Applicant/Dependent(s) completely and accurately. ☐ Yes ☐ No

Signature of Agent/Producer______________________
Office Name ______________________Office Address ______________________
Agent/Producer's License/ID Number ______________________
Signature of Agent/Producer______________________
Office Name ______________________Office Address ______________________
Agent/Producer's License/ID Number ______________________