(Medical)

HEADQUARTERS
625 State Street
P.O. Box 2207
Schenectady, NY 12301-2207
518/370-4793
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Enrollment/Change Form

For a Self-Insured Plan Offered by Your Employer and Administered by MVP Select Care, Inc.

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

1 PLEASE PROVIDE US WITH INFORMATION ABOUT YOURSELF

Employee Name *(Last, First, Initial, Suffix)* _____ Sex ☐ M ☐ F

Address _____ City _____ State _____ Zip _____ County _____

Home Phone _____ Business Phone _____ Email Address _____

Employer _____

Employer Address _____ City _____ State _____ Zip _____

Date Employed _____ ☐ Full Time ☐ Part Time

Marital Status ☐ Single ☐ Married **Marriage Date:** __/__/__

Is your spouse employed? ☐ Yes ☐ No If yes, by whom? _____

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

Spouse has ☐ Individual Coverage ☐ Family Coverage Spouse's health insurance ID# _____

Eligible for Medicare? Employee ID# _____ Spouse ID# _____

Employee ☐ A Effective Date _____ ☐ B Effective Date _____ Spouse ☐ A Effective Date _____ ☐ B Effective Date _____

2 PLEASE INDICATE ENROLLMENT/CHANGE

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

☐ PPO ☐ Indemnity

4 PLEASE PROVIDE IMPORTANT INFORMATION FOR ALL FAMILY MEMBERS

Relationship to Employee	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 26 years of age, unless a student or disability waiver is attached if necessary. **To obtain a waiver, call MVP.** Please note: Your employer's plan requirements may differ.

5 PLEASE SIGN (Employee, spouse, and all dependents 18 years of age or older must sign.)

I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

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

Spouse's Signature x _____ **Date** _____

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

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

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6 TO BE COMPLETED BY EMPLOYER

Group # _____

Subgroup # _____

Effective Date _____

Product(s) # _____ _____

Employer Class _____

If Applicable: Employee Dept. _____

Employee Type _____

Employee Location _____

Approved by _____