Medicare Advantage Health Plans

Employer Group Enrollment Application and Part D Application

MVP HEALTH CARE

By completing this Enrollment Application, I agree to the following:

MVP Health Plan, Inc. is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan.**

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: Annual Enrollment Period October 15–December 7 of every year), or through my employer group.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

Once I am a member of MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date MVP coverage begins, I must get all of my health care from MVP, except for emergency or urgently needed services, or out-of-area dialysis services. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **neither Medicare nor MVP will pay for these services**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MVP, he/she may be paid based on my enrollment in MVP.

Please complete Steps 1–6 on the following pages. Complete one enrollment form per applicant.

Step 1: Plan Enrollment Selection for Employer Group or Union Member (Please print)

Employer or Union Name **Group No.**

Please check which employer group plan you are enrolling in:

- ☐ **Preferred Gold HMO-POS with** MVP Part D prescription drug coverage
- ☐ **GoldAnywhere PPO with** MVP Part D prescription drug coverage
- ☐ **USA Care PPO with** MVP Part D prescription drug coverage

Date Coverage Should Begin (MM/DD/YYYY)

Step 2: Applicant Information (Please print)

Name (last, first, middle initial)

Permanent Residence (Home) Street Address (PO Box is not allowed)

City **State** **Zip Code** **County** ☐ **Male** ☐ **Female**

Home Phone Number **Date of Birth** (MM/DD/YYYY) **Gender**

Mailing Address (if different from permanent address above)

City **State** **Zip Code**

Email

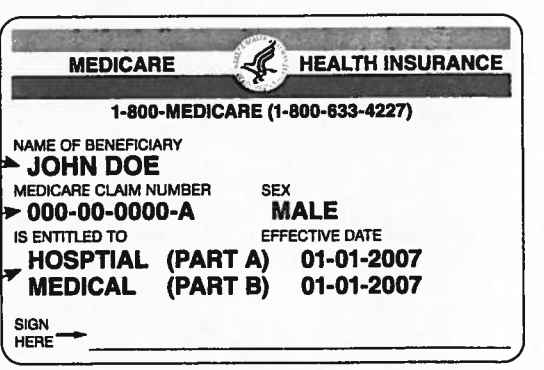
Step 3: Please Provide Your Medicare Insurance Information (Please print)

Using your Medicare card, fill in these blanks so they match your red, white, and blue Medicare card. Or attach a copy of your Medicare card, or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name of Beneficiary

Medicare Claim Number

Hospital Part A Effective Date **Hospital Part B Effective Date**



Step 4: Provide Your Primary Care Physician (PCP)—not required for GoldAnywhere PPO or USA Care PPO

Are you an existing patient? ☐ **Yes** ☐ **No**

PCP Full Name

Step 5: Please Read and Answer These Important Questions (Please print)

1. Are you the retiree?

   ☐ **Yes** **Your retirement date** (MM/DD/YYYY) _____

   ☐ **No** **Name of retiree** _____

2. Are you covering a spouse or dependents under this employer or union plan?

   ☐ **Yes** **Name of Spouse** **Names of Dependents** _____

   ☐ **No**

3. Do you or your spouse work? ☐ **Yes** ☐ **No**

4. Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits, EPIC (New York) or V-Pharm (Vermont).
   Will you have other prescription drug coverage in addition to MVP? ☐ **Yes** ☐ **No**
   If yes, refer to the ID card for your other drug coverage and provide the following information:

   Name of other coverage **Effective Date**

   Rx ID # **Rx Group #** **Rx BIN #** **Rx PCN**

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** *(provide information below)* ☐ **No**

   Name of institution

   Address (number and street) **Phone Number**

Step 6: Provide YourSsignature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent that MVP will release my information (which may include prescription information, medical information, HIV, mental health, and /or alcohol and substance abuse information) to Medicare, health care providers, or organizations involved in my care, and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that MVP will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment; and 2) documentation of this authority is available upon request from Medicare.

Please Sign Below

Signature **Today's Date**

If you are the authorized representative, you must sign on the previous page and provide the following information about yourself:

Name **Relationship to Enrollee**

Address **Phone Number**

Please contact MVP if you need this information explained to you in another language or provided in a different format (Braille). Call **1-800-324-3899**, Monday–Friday, 8 am–8 pm Eastern Time. October 1–February 14, call seven days a week 8 am–8 pm. TTY: **1-800-662-1220**.

MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in MVP Health Plan depends on contract renewal. You must continue to pay your Medicare Part B premium.

For Office Use Only

Plan ID #: **Name of staff member/agent/broker (if assisted in enrollment):** **Agent License #:**

Effective date of coverage: **ICEP/IEP** **AEP** **SEP type** **Not eligible**