



Medicare Advantage Health Plans Enrollment Application & Part D Application EMPLOYER GROUP

By completing this enrollment application, I agree to the following:

MVP 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 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 from October 15 - December 7); 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 THE 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.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.



**Please complete both pages.
Complete one enrollment form per applicant.**

Section 1: Plan enrollment selection for employer group or union members

Employer or union name _____ Group # _____

Please check which plan you want to enroll in:

- ☐ Preferred Gold HMO with MVP Part D Prescription Drug
- ☐ GoldAnywhere PPO with MVP Part D Prescription Drug
- ☐ USA Care PPO with MVP Part D Prescription Drug
- ☐ Preferred Gold HMO without MVP Part D Prescription Drug

Section 2: Member information

LAST Name _____ FIRST Name _____ Mid. Init. _____

Permanent Street Address (*P.O. Box is not allowed*) _____

City _____ State _____ ZIP Code _____ County _____

Home Phone Number () _____ Date of Birth ____ / ____ / ____ Sex: ☐ M ☐ F

Mailing Address (*only if different from your permanent residence address*)

Street Address _____

City _____ State _____ ZIP Code _____

Section 3: Medicare card information

Please take out your Medicare card to complete this section.

- Please 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.

Medicare Health Insurance

Name _____ Medicare Claim # _____

Is Entitled To: Hospital (Part A) ____ / ____ / ____ Medical (Part B) ____ / ____ / ____

Section 4: Primary Care Physician (PCP) – not required for GoldAnywhere PPO or USA Care PPO

Primary Care Physician (*full name required*) _____

Existing patient? ☐ Yes ☐ No

Section 5: Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No
If yes, retirement date (*month/day/year*) _____ If no, name of retiree _____
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
If yes, name of spouse _____
Names of dependents _____
3. Do you or your spouse work? ☐ Yes ☐ No
4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you answered yes to this question and you don't need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.
5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs (EPIC).
Will you have other prescription drug coverage in addition to MVP? ☐ Yes ☐ No
If yes, name of other coverage _____
ID # for coverage _____

Your answer to the following question will not keep you from enrolling in this plan.

6. Are you a resident in a long term care facility, such as a nursing home? ☐ Yes ☐ No
If yes, please provide the following information:
Name of Institution: _____
Address & phone number of Institution (number and street): _____

Section 6: Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare 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 by MVP or by Medicare.

PLEASE SIGN BELOW

Signature _____ Today's Date _____

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone Number _____ Relationship to Enrollee _____

Please contact MVP if you need information in another language or format (Braille).

Our office hours are:
Monday – Friday, 8 am – 5 pm Eastern Time
From November 15 – March 1,
representatives are available every day from 8 am – 8 pm
1-888-280-6205
TTY: 1-800-662-1220

For Office Use Only

Enter in: ☐ Amisys ☐ Facets	If current member, please include member ID number: A OR 8
Previous ID # _____ Group Name _____ Group # _____	
Effective Date Requested _____ Input Date _____ Initials _____	
☐ ICEP/IEP ☐ AEP ☐ SEP (type): _____ Not eligible: _____	
Date coverage should begin: _____/_____/_____ (employer group use only)	
Name of staff member/agent/broker (if assisted in enrollment): _____	