



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 **B** Termination Remove Dependent(s) only (please specify) _____

Reason: _____ 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 <input type="checkbox"/> M <input type="checkbox"/> F	_____	____/____/____	____/____/____		
<input type="checkbox"/> Spouse	_____	____/____/____	____/____/____		
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

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.**
 ViIP is MVP's Vermont Non-group Indemnity Plan offered by MVP Health Insurance Company
 ViIP ENROLLMENT FORM

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):
- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Back Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> 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):
- | | |
|---|--|
| <input type="checkbox"/> Sought or been advised to seek treatment for any illness or injury | |
| <input type="checkbox"/> Had surgery | <input type="checkbox"/> Had a medical examination or medical care |
| <input type="checkbox"/> Been hospitalized | <input type="checkbox"/> 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) _____
Name _____ Condition(s) _____
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 _____
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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. _____

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.

7 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.

7 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 _____