Health Plan Enrollment or Change
for New York State Large Group Plans

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Termination** *Please complete all pages of this form.*

To be Completed by Employer *(please include Group Name, Group No., and Applicant Name on pages 2 and 3)*

Group Name	Group No.	Subgroup No.

Employee Class	Product ID No.	Effective Date

Section 1: Information About Yourself *(please print)*

Applicant Name *(First, Middle Initial, Last)* | Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code

County | Home Phone No. ( ) | Mobile Phone No. ( )

Email

Are you and/or your spouse eligible for Medicare? ☐ **Yes** ☐ **No**

If ***Yes***, provide your Medicare Member ID No(s).
(Yourself) (Spouse, if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates
(Yourself) Part A Part B (Spouse) Part A Part B

Section 2: Enrollment/Change/Termination Information

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependent ☐ Name Change
☐ Transfer to Another Plan ☐ Address Change ☐ COBRA

Requested Effective Date

Reason

☐ New Hire (Date of Hire:) ☐ Open Enrollment
☐ Qualifying Event *(explain)*
☐ Other

Termination

☐ Terminate from Plan
☐ Remove Dependent(s) only *(specify name or member ID no.)*

Requested Effective Date

Reason for Termination

☐ Termination of Employment ☐ Opting for Other Coverage
☐ Moved from Service Area
☐ Other

Section 3: Coverage Selection (Enrollments and Changes)

Medical Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Medical Plan Name (e.g., Gold 2 HDHP)

Optional Vision Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family
Vision coverage must be equal to or less than medical coverage.

Optional Vision Plan (select one) ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

Optional Dental Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

If scanning this form for submission, be sure to scan and return all pages of this form.

Continued on page 2

Group Name *Group No.* *Applicant Name*

Section 4: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

Please use a separate form for additional individuals.

For HMO and POS plan applicants, you (Applicant) and each individual listed below must designate a choice of Primary Care Physician (PCP). To search for doctors in our network, visit **mvphealthcare.com/findadoctor** or contact the MVP Customer Care Center at **1-888-687-6277** for assistance.

1 Applicant ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Are you already a patient of this physician? ☐ Yes ☐ No | PCP No.

2 Name *(First, Middle Initial, Last)* | ☐ Male ☐ Female ☐ Non-Binary | Relationship to Applicant ☐ Spouse ☐ Dependent

Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

3 Name *(First, Middle Initial, Last)* | ☐ Male ☐ Female ☐ Non-Binary | Relationship to Applicant ☐ Dependent

Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

4 Name *(First, Middle Initial, Last)* | ☐ Male ☐ Female ☐ Non-Binary | Relationship to Applicant ☐ Dependent

Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

5 Name *(First, Middle Initial, Last)* | ☐ Male ☐ Female ☐ Non-Binary | Relationship to Applicant ☐ Dependent

Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

Continued on page 3

Group Name	*Group No.*	*Applicant Name*

Section 5: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

On behalf of myself and any members of my family for whom I have enrollment authority and have listed on this enrollment form, I (we) hereby apply for membership in MVP. I hereby consent to the release, use, and disclosure of any medical information about me and any members of my family for whom I can give consent:

- By my primary care provider, any other health care provider, or the New York State Department of Health ("NYSDOH") to MVP and any health care providers involved in caring for me or my family, as reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations functions, or other functions permitted by, and in accordance with, applicable laws, regulations, and rules. This may include pharmacy and other medical claims information needed to help manage my care;
- By MVP and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administering health programs to the extent permitted by, and in accordance with, applicable laws, regulations, and rules; and
- By MVP to my providers or other persons or organizations, as reasonably necessary for MVP or my providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

At any time, I can take away the permission I gave to release information. All I have to do is call the MVP Customer Care Center at the phone number listed on the back of my MVP Member ID card.

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

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

☐ Yes ☐ No

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

I have read and agree to this authorization.

Signature *Date*

Privacy Notice

MVP Health Plan Inc., MVP Health Services Corp., MVP Health Insurance Company, and Hudson Health Plan, Inc.

Effective Date

This Notice of Privacy Practices is effective as of April 1, 2014 and revised February 11, 2022.

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

MVP Health Plan, Inc., MVP Health Services Corp., MVP Health Insurance Company, and Hudson Health Plan, Inc. (collectively "MVP") respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you with this notice of our privacy practices and legal duties and to abide by the terms of this notice.

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and state laws and regulations regarding the confidentiality of health information, MVP provides this notice to explain how we may use and disclose your health information to carry out payment and health care operations and for other purposes permitted or required by law. Health information is defined as enrollment, eligibility, benefit, claim, and any other information that relates to your past, present, or future physical or mental health.

The terms and conditions of this privacy notice supplement any other communications, policies, or notices that MVP may have provided regarding your health information. In the event of conflict between this notice and any other MVP communications, policies, or notices, the terms and conditions of this notice shall prevail.

MVP's Duties Regarding Your Health Information

MVP is required by law to:

- Maintain the privacy of information about your health in all forms including oral, written, and electronic.
- Train all MVP employees in the protection of oral, written, and electronic protected health information (PHI).
- Limit access to MVP's physical facility and information systems to the required minimum necessary to provide services.
- Maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard PHI.
- Notify you following a breach of unsecured health information.
- Provide you with this notice of our legal duties and health information privacy rules.
- Abide by the terms of this notice.

We reserve the right to change the terms of this notice at any time, consistent with applicable law, and to make those changes effective for health information we already have about you. Once revised, we will advise you that the notice has been updated, provide you with information on how to obtain the updated notice, and will post it on **mvphealthcare.com**.

How We Use or Disclose Your Health Information

As a member, you agree to let MVP share information about you for treatment, payment, and health care operations. The following are ways we may use or disclose your health information.

For treatment. We may share your health information with a physician or other health care provider in order for them to provide you with treatment.

For payment. We may use and/or disclose your health information to collect premium payments, determine benefit coverage, or to provide payment to health care providers who render treatment on your behalf.

For health care operations. We may use or disclose your health information for health care operations that are necessary to enable us to arrange for the provision of health benefits, the payment of health claims, and to ensure that our members receive quality service. For example, we may use and disclose your health information to conduct quality assessment and improvement activities (including, e.g., surveys), case management and care coordination, licensing, credentialing, underwriting, premium rating, fraud and abuse detection, medical review, and legal services. We will not use or disclose your health information that is genetic information for underwriting purposes. We also use and disclose your health information to assist other health care providers in performing certain health care operations for those health care providers, such as quality assessment and improvement, reviewing the competence and qualifications of health care providers, and conducting fraud detection or investigation, provided that the information used or disclosed pertains to the relationship you had or have with the health care provider.

Health-related benefits and services. We may use or disclose your health information to tell you about alternative medical treatments and programs, or about health-related products and services that may be of interest to you.

Disclosures to a business associate. We may disclose your health information to other companies that perform certain functions on our behalf. These companies are called Business Associates. These Business Associates must agree in writing to protect your privacy and follow the same rules we do.

Disclosures to a plan sponsor. We may disclose limited information to the plan sponsor of your group health plan (usually your employer) so that the plan sponsor may obtain premium bids, modify, amend, or terminate your group health plan and perform enrollment functions on your behalf.

Disclosures to a third-party representative. We may disclose to a Third-Party Representative (family member, relative, friend, etc.) health information that is directly relevant to that person's involvement with your care or payment for care if we can reasonably infer that the person is involved in your care or payment for care and that you would not object.

Disclosures to a third-party application. You may direct MVP to provide specific information it maintains about you, including health information, through a third-party application chosen by you. If so, MVP may disclose your information to one or more third-party applications as directed by you.

Email or telephonic communications to you. You agree that we may communicate as allowed by applicable law via email or phone, including by text message, with you regarding insurance premiums or for other purposes relating to your benefits, claims, or our products/services. Your agreement includes consent to receive email, phone, or text message communications from us to the extent such consent is required or allowed by applicable law, including as may be allowed or required under the Telephone Consumer Protection Act. Further, you understand that such communications (utilizing encryption software for our email transmissions or other security controls for phone and text message) may contain confidential information, protected health information, or personally identifiable information.

Disclosures authorized by you. Except for the scenarios described in this notice, HIPAA prohibits the disclosure of your health information without first obtaining your authorization. MVP will not use or disclose your health information to engage in marketing, other than face to face communications, the offering of a promotional gift, or as set forth in this notice, unless you have authorized such use or disclosure. MVP will not use or disclose your health information for any reason other than those described above, unless you have provided authorization. We can accept an Authorization to

Disclose Information form if you would like us to share your health information with someone for a reason we have not stated above. Using this form, you can designate whom you would like us to share information with, what information you would like us to share, and how long you want us to be able to share your information with that individual. A copy of this form is available by calling the MVP Customer Care Center or at **mvphealthcare.com**. You must complete this form and send it to the address or fax it to the fax number on the form. You can cancel this Authorization at any time in writing and per the requirements on the form.

Disclosures to Parents of Minors

MVP has a policy in place to protect the privacy of minors with sensitive diagnoses. MVP has developed this position based upon legal requirements together with MVP's commitment to safeguarding the privacy of its members who receive care for sensitive needs.

If a minor 12–18 years old receives services or treatment related to mental health, chemical dependency or substance abuse, venereal disease, HIV/AIDS, family planning, prenatal care, or abortion-related services, MVP must have an Authorization to Disclose Information form on file from the minor to disclose most information to a parent or guardian. Please note that MVP can always share benefit/eligibility/cost-share information with a subscriber for their dependents.

You can find the *Authorization to Disclose Information* form at **mvphealthcare.com/members**. Select *Forms*, then *Disclosure/Payment Forms, and Services Requiring Prior Authorization*. You can also call MVP Customer Care at the phone number listed on the back of your MVP Member ID card (TTY: 1-800-662-1220).

Special Use and Disclosure Situations

Under certain circumstances, as required by law, MVP would be required to share your information without your permission. Some circumstances include the following.

Uses and Disclosures required by law. We may use and disclose health information about you when we are required to do so by federal, state, or local law.

Public health. We may disclose your health information for public health activities. These activities include preventing or controlling disease, injury, or disability; reporting births or deaths; or reporting reactions to medications or problems with medical products, or to notify people of recalls of products they have been using.

Health oversight. We may disclose your health information to a health oversight agency that monitors the health care system and government programs for designated oversight activities.

Legal proceedings. We may disclose your health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and, in certain situations, in response to a subpoena, discovery request, or other lawful process.

Law enforcement. We may disclose your health information, so long as applicable legal requirements are met, for law enforcement purposes.

Abuse or neglect. We may disclose your health information to a public health authority, or other government authority authorized by law to receive reports of child abuse, neglect, or domestic violence consistent with the requirements of applicable federal and state laws.

Coroners, funeral directors, and organ donation. We may disclose your health information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose your health information to funeral directors as necessary to carry out their duties. If you are an organ donor, we may release your health information for procurement, banking, or transplantation.

Research purposes. In certain circumstances, we may use and disclose your health information for research purposes.

Criminal activity. We may disclose your health information when necessary to prevent or lessen serious and imminent threat to the health and safety of a person or the public.

Military activity. We may disclose your health information to authorized federal officials if you are a member of the military (or a veteran of the military).

National security. We may disclose your health information to authorized federal officials for national security, intelligence activities, and to enable them to provide protective services for the President and others.

Workers' compensation. We may disclose your health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

What are your rights?

The following are your rights with respect to your health information. Requests for restrictions, confidential communications, accounting of disclosures, amendments to your health information, to inspect or copy your health information, or questions about this notice can be made by using the Contact Information below.

Right to request restrictions. You have the right to request a restriction or limitation on your health information we disclose for payment or health care operations. You also have the right to request a limit on the information we disclose about your health to someone who is involved in your care or the payment for your care, like a family member, relative, or friend. While we will try to honor your request, we are not legally required to agree to restrictions or limitations. If we agree, we will comply with your request or limitations except in emergency situations.

Right to request confidential communications. You have the right to request that we communicate with you about your health information in a certain way or at a certain location if the disclosure of information could endanger you. We will require the reason for the request and will accommodate all reasonable requests.

Right to an accounting of disclosures. You have the right to request an accounting of disclosures of your health information made by us other than those necessary to carry out treatment, payment, and health care operations, disclosures made to you or authorized by you, or in certain other situations.

Right to inspect and obtain copies of your health information. You have the right to inspect and obtain a copy of certain health information that we maintain. In limited circumstances, we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing of the reason for the denial and if applicable the right to have the denial reviewed.

Right to amend. If you feel that the health information we maintain about you is incomplete or inaccurate, you may ask us to amend the information. In certain circumstances we may deny your request. If we deny the request, we will explain your right to file a written statement of disagreement. If we approve your request, we will include the change in your health information and tell others that need to know about your changes.

Right to a copy of the notice of privacy practices. You have the right to obtain a copy of this notice at any time.

Exercising Your Rights

Unless you provide us with a written authorization, we will not use or disclose your health information in any manner not covered by this notice. If you authorize us in writing to use or disclose your health information in a manner other than described in this notice, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization; however, we will not reverse any uses or disclosures already made in reliance on your authorization before it was revoked.

You have a right to receive a paper copy of this notice at any time. You can also view this notice at **mvphealthcare.com**.

If you believe that your privacy rights have been violated, you may file a complaint by contacting an MVP Customer Care Representative at the address or phone number indicated in the Contact Information below.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request.

We Will Not Take Any Action Against You for Filing a Complaint

We will not retaliate in any way if you choose to file a complaint in good faith with us or with the U.S. Department of Health and Human Services. We support your rights to the privacy of your medical information.

Contact Information

MVP Medicaid Customer Care Center
1-800-852-7826 (TTY 1-800-662-1220)

MVP Medicare Customer Care Center
1-800-665-7924 (TTY 1-800-662-1220)

Customer Care Center for All Other MVP Members
1-888-687-6277 (TTY 1-800-662-1220)

Mail all written communications to:
MVP CUSTOMER CARE CENTER
PO BOX 2207
SCHENECTADY NY 12301-2207