Employer Group Enrollment Application

For MVP Health Care® Medicare Advantage Health Plans with Part D

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: 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. MVP's Medicare Advantage plans offer worldwide coverage for emergency care.

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.

MVP Health Plan, Inc. is an HMO-POS/PPO organization with a Medicare contract.
Enrollment in MVP Health Plan depends on contract renewal.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR§§ 422.50, 422.60, 423.30, and 423.32 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Please complete Sections 1–6. Complete one enrollment application per applicant.

Please contact the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY 711) if you need information in a language other than English, or in an accessible format. Call seven days a week, 8 am–8 pm Eastern Time. April 1–September 30, call Monday–Friday, 8 am–8 pm.

Section 1: Employer Group or Union Information/Your Plan Selection

Employer or Union Name	Group No.	Date Coverage to Begin
Rochester City School District	**700216**	

Please select the Employer Group plan in which to enroll:

☐ **MVP Preferred Gold® Standard** (HG230034/RHG0301X)

☐ **MVP Preferred Gold® Buy Up** (HG230036/RHG0301X)

Section 2: Information About Yourself *(please print)*

Name *(Last, First, Middle Initial)*	Gender ☐ **Male** ☐ **Female**	Date of Birth

Preferred Residence Street Address *(PO Box is not allowed)*	Preferred Phone No. ( )

City	State	Zip Code	County

Mailing Address *(if different from Permanent Address)*	City	State	Zip Code

Email Address *(optional)*

Are you of any of the following origins? *(select all that apply)*

Answering this question is your choice. You cannot be denied coverage if you don't select an answer.

☐ **Mexican, Mexican American, Chicano/Chicana**
☐ **Puerto Rican**
☐ **Cuban**
☐ **Other Hispanic, Latino/Latina, or Spanish**
☐ **Not of any of the listed origins**
☐ **I choose not to answer**

Name *Employer Group No.*

*(**Section 2: Information About Yourself** continued)*

What is your race? *(select all that apply)*

Answering this question is your choice. You cannot be denied coverage if you don't select an answer.

- ☐ **American Indian or Alaska Native**
- ☐ **Asian Indian**
- ☐ **Black or African American**
- ☐ **Chinese**
- ☐ **Filipino**
- ☐ **Guamanian or Chamorro**
- ☐ **Japanese**
- ☐ **Korean**
- ☐ **Native Hawaiian**
- ☐ **Other Asian**
- ☐ **Other Pacific Islander**
- ☐ **Samoan**
- ☐ **Vietnamese**
- ☐ **White**
- ☐ **I choose not to answer**

Section 3: Information About Your Medicare Insurance

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.

Your Name *(as it appears on your Medicare card)* _____

Your Medicare Number *(XXXX-XXX-XXXX)* _____

Effective Dates

Hospital (Part A) _____ Medical (Part B) _____

Section 4: Your Primary Care Physician (PCP)

PCP's Full Name _____

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

Section 5: Read and Provide Answers to the Following Questions *(please print)*

1. Are you the retiree?

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

☐ **No** Retiree's Name: _____

2. Are you covering a spouse or dependent(s) under this Employer or Union plan?

☐ **Yes** Name of spouse _____ ☐ **No**

Name(s) of dependent(s) _____

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

Name *Employer Group No.*

*(**Section 5** continued)*

4. Will you have other prescription drug coverage in addition to MVP? ☐ **Yes** ☐ **No**
Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, EPIC (NY), or V-Pharm (VT).

If ***Yes***, refer to the ID card for your other drug coverage and provide the following:

Name of Other Coverage | Effective Date

Rx ID No. | Rx Group No. | Rx BIN No. | Rx PCN

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**

If ***Yes***, provide the following information about the facility:

Name of Institution | Phone No.

Street Address

6. Have you served in the military? ☐ **Yes** ☐ **No**

Section 6: Your Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent to the release, use, and disclosure of my information (which may include prescription information, medical information, HIV, mental health, and/or alcohol and substance abuse information) by MVP Health Care® (MVP) or any health care provider involved in caring for me to Medicare, MVP, or any health care providers, or organizations involved in my care, and other plans as is reasonably necessary for MVP or my health care 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. I also acknowledge that MVP may release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. I also acknowledge that MVP may release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. 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.

By providing my email address, I give permission for MVP to send me emails related to my plan and benefits. 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 **my.mvphealthcare.com** and selecting *Communication Preferences* or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

Name *Employer Group No.*

*(**Section 6: Your Signature and Authorization** continued)*

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.

Signature *Today's Date*

If you are the authorized representative, sign above and provide the information below about yourself.

Name	Relationship to Enrollee	Preferred Phone No.

Street Address	City	State	Zip Code

Office Use Only

Name of Staff Member/Agent/Broker *(if assisted in enrollment)* Plan ID No. Effective Date of Coverage

ICEP/IEP AEP SEP (type) Not Eligible Agent License No.

Paperwork Reduction Act Disclosure Statement

According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Blvd, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on the cover page to send your completed form to the plan.