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.
Roofers Local 241 Security Plan		

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

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

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: Choose Your Coverage (Enrollments and Changes)~~

☐ ~~HMO~~ ☒ ~~PPO~~ ☐ ~~POS~~ ☐ ~~EPO~~ ☐ ~~HDHP EPO~~ ☐ ~~HDHP PPO~~ ☐ ~~Dental~~

~~HMO Health Maintenance Organization plan~~ ~~PPO Preferred Provider Organization plan~~ ~~POS Point of Service plan~~ ~~EPO Exclusive Provider Organization plan~~
~~HDHP EPO High Deductible Health Plan Exclusive Provider Organization~~ ~~HDHP PPO High Deductible Health Plan Preferred Provider Organization~~

~~*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*
Roofers Local 241 Security Plan		

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** and select *Find a Doctor*, or contact the MVP Customer Care Center at **1-888-687-6277** for assistance.

1 Applicant ☐ Male ☐ Female | 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)* | Relationship to Applicant ☐ Spouse ☐ Dependent

☐ Male ☐ Female | 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)* | Relationship to Applicant ☐ Dependent

☐ Male ☐ Female | 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)* | Relationship to Applicant ☐ Dependent

☐ Male ☐ Female | 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)* | Relationship to Applicant ☐ Dependent

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

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