Health Plan Enrollment or Change
for Vermont Group Plans

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

To be Completed by Employer *(please include the Group Name and Number on page 2)*

Group Name	Group No.	Subgroup No.	Employee Class	Effective Date
EF WALL AND ASSOCIATES INC	**429788**			**01/01/2025**

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

☐ Standard ☐ Non-Standard ☐ Medical Plan Name *(e.g. Gold 4 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

Please note: *Premium paid by employer group for Reflective plans is not eligible for the Small Business Health Care Tax Credit.*

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

Continued on page 2

Group Name EF WALL AND ASSOCIATES INC *Group No.* 429788 *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.

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

2 Name *(First, Middle Initial, Last)* | Relationship to Applicant ☐ Spouse ☐ Dependent

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

3 Name *(First, Middle Initial, Last)* | Relationship to Applicant ☐ Dependent

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

4 Name *(First, Middle Initial, Last)* | Relationship to Applicant ☐ Dependent

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

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 applicable Vermont regulatory agency 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 applicable Vermont regulatory agency 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.

I also agree that the information released for treatment, payment, and health care operations may include information about me concerning HIV and/or mental health, to the extent permitted by applicable laws, until I revoke this consent.

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 may also be subject to a civil penalty.

I have read and agree to this authorization.

Signature *Date*