



MVP Health Plan, Inc.
 MVP Health Insurance Company
 MVP Health Services Corp.
 625 State Street
 Schenectady, NY 12305

GROUP APPLICATION

1 SECTION ONE GROUP INFORMATION

Company Name _____
 Address _____
 City _____
 State _____ Zip _____ County _____
 Telephone No. () _____ Fax No. () _____
 Group Contact Name _____
 Title _____
 Telephone No. () _____ Fax No. () _____
 Email _____
This person will receive an MVP log in.
 Additional Office Locations _____

 SIC Code _____
 Tax ID # (required) _____
 Type of Group: Employer Group or Employer Trust
 Association or Chamber
 Multiple Employer Trust _____
 Taft Hartley Trust
 Labor Union
 Member of Controlled Group or Corporation

2 SECTION TWO BILLING INFORMATION

Billing Contact (if different from above) _____

 Title _____
 Address (if different from above) _____
 City _____ State _____ Zip _____
 Telephone No. () _____ Fax No. () _____
 Email _____

3 SECTION THREE OTHER GROUP CONTACT (if applicable)

Name _____
 Title _____
 Email _____ Phone _____
 Name _____
 Title _____
 Email _____ Phone _____

4 SECTION FOUR PRODUCT SELECTION

PLAT # _____ BRONZE # _____
 GOLD # _____ OTHER
 SILVER # _____ SILVER 4 w/Embedded HRA
 MEDICARE GOLD HEALTHY NY
 MVP DENTAL PPO MVP DENTAL FOR KIDS*
 DELTA DENTAL PPO*

*If you have purchased this ACA required benefit through another carrier, please complete Section 8. (Not required if you are selecting MVP Dental PPO.)

Desired Effective Date _____

5 SECTION FIVE GROUP ADMINISTRATION

Total number of employees including full-time¹, part-time equivalent², seasonal equivalent², and 1099 _____

Note: Retirees³ and COBRA participants are not considered "employees" and should not be counted to determine group size.

New hire eligibility policy:

Date of hire
 First of the month following date of hire
 First of the month following _____ days of employment (may not exceed 90 days)

¹The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size. This method is the same calculation used to determine employer liability under the "Shared Responsibility for Employers" provisions of the ACA and Internal Revenue Code.

²To convert the number of part-time employees to a full-time equivalent, the aggregate number of hours worked for part-time employees is divided by 120. Part-time hours are capped at 120 hours per employee per month.

³Exceptions will be made if the retiree population is more than 25% of the group. If the retiree population makes up more than 25% of the group, then the retirees will be included in the group size count.

6 SECTION SIX-OTHER GROUP COVERAGE IN ADDITION TO MVP

1. Name of Other Insurer _____

Type of Coverage and Plan Design (metal level) _____

Effective Date of Policy _____

2. Name of Other Insurer _____

Type of Coverage and Plan Design (metal level) _____

Effective Date of Policy _____

7 SECTION SEVEN-ENROLLMENT CLASS/SUBGROUP

Class Description (ex: All employees working more than 20 hrs/week) _____

Does your group need a separate class/subgroup assigned for:

- Gold Salary
 Cobra Union
 Hourly Other _____

8 SECTION EIGHT-STAND-ALONE DENTAL COVERAGE

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York State of Health: The Official Health Plan Marketplace-certified stand-alone dental plan offered outside the New York State of Health: The Official Health Plan Marketplace? Yes No

If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.

9 SECTION NINE CERTIFICATION

To the best of my knowledge, all the statements/responses in this application are true and complete.

By signing this application, I certify that under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business.

Insurance Fraud Statement

I understand that any person who knowingly and with the 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 (\$5,000) and the stated value of the claim for each such violation.

Print Name _____

Signature _____

Title _____

Date _____

10 SECTION TEN BROKER INFORMATION

Broker Name _____

Email _____

Firm Name _____

Address _____

City _____ State _____ Zip _____

Telephone No. () Fax No. ()

11 SECTION ELEVEN MVP REPRESENTATIVE SECTION

The information provided in this application is true to the best of my knowledge.

Was a Broker involved in this sale? Yes MVP Broker # _____
 No

Print Name _____

Signature _____

Date _____

QUESTIONS?

Call **1-800-TALK-MVP (825-5687)** or visit **DiscoverMVP.com**.

MVP partners with Healthplex for network services and benefit administration to ensure our members receive the most comprehensive oral care and best possible member service.

