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	#__________	☐ DENTAL	#__________
☐ SILVER	#__________	☐ OTHER	#__________

☐ MEDICARE GOLD __________

☐ PEDIATRIC DENTAL* __________
(required Small Group Coverage)

☐ HEALTHY NY #__________

If you have purchased this required benefit through another carrier, please complete Section 8.

Desired Effective Date ________________

5 SECTION FIVE GROUP ADMINISTRATION

A. Total number of employees (working a minimum of 20 hours/week) __________

B. Number of retirees eligible for coverage __________

C. Number of net eligible participants __________

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)

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 ______________________

Was your Group terminated for non-payment of premium within the last 12 months? ☐ Yes ☐ No

Continued

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 Health Benefit Exchange-certified stand-alone dental plan offered outside the New York Health Benefit Exchange? ☐ 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 ____

*Pediatric Dental benefits are underwritten and administered by Delta Dental of New York, Inc.
Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055
1-800-932-0783
www.deltadentalins.com