



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

# Small Group Application

## 1 Section One Group Information

Company Name \_\_\_\_\_

Address \_\_\_\_\_

SIC Code \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Telephone No. ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_

HBA Name \_\_\_\_\_

Title \_\_\_\_\_

Telephone No. ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_

Email \_\_\_\_\_

Additional Office Locations \_\_\_\_\_

\_\_\_\_\_

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

Provide description of Group (this description must address type of business or association, years in existence, present ownership)

\_\_\_\_\_

\_\_\_\_\_

## 2 Section Two Billing Information

Billing Statement to be sent to (If different from HBA above) \_\_\_\_\_

\_\_\_\_\_

Address (If different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_

Email \_\_\_\_\_

## 3 Section Three Product Selection

**Include MVP quotes for products selected**

HMO                       PPO  
 HDHP EPO               EPO  
 DENTAL                   INDEMNITY  
 POS                         MEDICARE ADVANTAGE (INFORMATIONAL ONLY)  
 HDHP PPO               TRIVANTAGE

Desired Effective Date \_\_\_\_\_

## 4 Section Four Group Administration

A. Total number of employees (full-time and part-time) \_\_\_\_\_

B. Total number of full-time employees  
 (working a minimum of 20 hours/week) \_\_\_\_\_

C. Number of retirees eligible for coverage  
 (Employer must contribute 50% or more of cost)  
 1) Non-Medicare Retiree \_\_\_\_\_  
 2) Medicare Retirees \_\_\_\_\_

D. Number of net eligible participants (B + C) \_\_\_\_\_

E. Number of COBRA/State Continuation Participants \_\_\_\_\_

F. Number of eligible employees/retirees waiving coverage \_\_\_\_\_

G. Total number of participants eligible to enroll (D + E - F) \_\_\_\_\_

## 5 Section Five Other Group Coverage in Addition to MVP

Name of Insurer \_\_\_\_\_

Address \_\_\_\_\_

Type of Coverage and Plan Design \_\_\_\_\_

\_\_\_\_\_

Effective Date of Policy \_\_\_\_\_

Name of Insurer \_\_\_\_\_

Address \_\_\_\_\_

Type of Coverage and Plan Design \_\_\_\_\_

\_\_\_\_\_

Effective Date of Policy \_\_\_\_\_

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

## 6 Section Six Enrollment Class/Subgroup

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

Employer Contribution      Single \_\_\_\_\_  
   Double \_\_\_\_\_  
   Parent + \_\_\_\_\_  
   Family \_\_\_\_\_  
   Retiree \_\_\_\_\_  
   Non-Medicare \_\_\_\_\_  
   Medicare \_\_\_\_\_

New Hire Eligibility Policy:    Date of Hire  
    First of the month following date of hire  
    First of the month following \_\_\_\_\_ days of employment

Indicate number of enrollees by type:      Single \_\_\_\_\_  
   Double \_\_\_\_\_  
   Parent + \_\_\_\_\_  
   Family \_\_\_\_\_  
   Medicare \_\_\_\_\_

## 6A Section Six (A) Enrollment Class/Subgroup

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

Employer Contribution      Single \_\_\_\_\_  
   Double \_\_\_\_\_  
   Parent + \_\_\_\_\_  
   Family \_\_\_\_\_  
   Retiree \_\_\_\_\_  
   Non-Medicare \_\_\_\_\_  
   Medicare \_\_\_\_\_

New Hire Eligibility Policy:    Date of Hire  
    First of the month following date of hire  
    First of the month following \_\_\_\_\_ days of employment

Indicate number of enrollees by type:      Single \_\_\_\_\_  
   Double \_\_\_\_\_  
   Parent + \_\_\_\_\_  
   Family \_\_\_\_\_  
   Medicare \_\_\_\_\_

## 7 Section Seven 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 \_\_\_\_\_

## 8 Section Eight Broker Information

Broker Name \_\_\_\_\_

Email \_\_\_\_\_

Firm Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. (    )                      Fax No. (    )

## 9 Section Nine 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   Facets ID \_\_\_\_\_

No

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

