

Vermont State Dental Society Member Practice

Due Date: NO Later than August 18th

Effective date: September 1, 2009

MVP HEALTH CARE REQUEST FOR GROUP COVERAGE +/-or CHANGE FORM

| | | | | |
|--|--------------------|---|--------------------------------|--|
| Practice Name: | | If Currently on a VSDS Plan include Group #: | | |
| Address: | | | | |
| City, State, Zip: | | | | |
| Contact Person for Health Benefits: | | | | |
| Phone Number: | Fax Number: | Email Address: | Total No. of Employees: | |

NEW PRACTICES ONLY - Prior Health Plan Information If NOT Currently on a VSDS Member Plan

| | | | |
|--|---------------------------|---------------------------|---------------------------|
| Name of Current Insurance Plan if NOT Currently on VSDS: _____ | Premium | | |
| Renewal Date: if NOT Currently with VSDS: _____ | Single \$ _____ | Double \$ _____ | Family \$ _____ |
| Number of Employees Enrolled in Current Insurance Plan: _____ Business contribution to total premium: _____ | | | |
| Provide MVP Enrollment Form for each new Subscriber | | | |

MVP Coverage – Please Choose NO MORE Than Two Options For Your Practice

| | | | | | | | | |
|---|--|--|--|---|--|--|--|--|
| <p><u>PPO or EPO Co-pay Plans - Circle Option(s) Desired:</u></p> <p>Preferred PPO - 3 – VP015 4 – VP016</p> <p>Preferred EPO - 5 – VE053</p> <p><u>High Deductible Health Plans:</u></p> <p>Preferred HDHP EPO - 7 – VEHD02 8 – VEHD03</p> <p>Preferred HDHP PPO - 9 – VEHD15</p> <p>Wish to: RENEW AS IS</p> | <p style="text-align: center;">Rates for 16 Months</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; vertical-align: top;"> <p>3</p> <p>Single: 549.45 Double: 1098.89 Family: 1483.51</p> </td> <td style="width: 50%; text-align: center; vertical-align: top;"> <p>4</p> <p>Single: 503.45 Double: 1006.90 Family: 1359.31</p> </td> </tr> <tr> <td colspan="2" style="text-align: center; vertical-align: top;"> <p>5</p> <p>Single: 405.15 Double: 810.31 Family: 1093.92</p> </td> </tr> <tr> <td style="text-align: center; vertical-align: top;"> <p>7</p> <p>Single: 336.11 Double: 672.23 Family: 907.51</p> </td> <td style="text-align: center; vertical-align: top;"> <p>8</p> <p>Single: 256.12 Double: 512.24 Family: 691.52</p> </td> <td style="text-align: center; vertical-align: top;"> <p>9</p> <p>Single: 297.25 Double: 594.50 Family: 802.58</p> </td> </tr> </table> | <p>3</p> <p>Single: 549.45 Double: 1098.89 Family: 1483.51</p> | <p>4</p> <p>Single: 503.45 Double: 1006.90 Family: 1359.31</p> | <p>5</p> <p>Single: 405.15 Double: 810.31 Family: 1093.92</p> | | <p>7</p> <p>Single: 336.11 Double: 672.23 Family: 907.51</p> | <p>8</p> <p>Single: 256.12 Double: 512.24 Family: 691.52</p> | <p>9</p> <p>Single: 297.25 Double: 594.50 Family: 802.58</p> |
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Please forward for approval an application to **MVP Health Care, 66 Knight Lane, Suite 10, Williston, VT 05495** or **Fax: 802-264-6507**. Please call the VT Marketing Department with any questions. 802-264-6500 or 800-380-3530. You may also contact Affiliated Associates for additional assistance at 802-861-2900 or 877-237-9094.

Request for Coverage Applications received after the **18th** of the month will not guarantee enrollment by the first of the month.

Authorized Signature _____ Date _____