



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 **VSDS**
 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 - 5 PPO - 1 - 2 - 3
 HDHP EPO - 8 EPO - 4
 POS - 6
 HDHP PPO - 7

Circle up to two plans

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 N-A _____
 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 Stefanie Pigeon

Email stefanie@affiliatedassoc.com

Firm Name Affiliated Associates

Address P.O. Box 8592

City Essex State VT Zip 05451

Telephone No. (802)861-2900 Fax No. (802)419-3091

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 _____

