By completing this enrollment application, I agree to the following:

MVP is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan.**

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7); or through my employer group.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date MVP coverage begins, I must get all of my health care from MVP, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also know as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR MVP WILL PAY FOR THESE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MVP, he/she may be paid based on my enrollment in MVP.
Step 1: Plan enrollment selection for employer group or union members

Employer or union name: Rochester Institute of Technology
Group #: 700187

Please check which employer group plan you are enrolling in:
- Preferred Gold HMO-POS with “Option 1” Part D Prescription Drug - $0/$10/$30/$60/$60/$0 (HG160023 / RHG0113X)
- Preferred Gold HMO-POS with “Option 2” Part D Prescription Drug - $0/$10/$35/$90/33%/$0 (HG160023 / RHG0105X)

Date coverage should begin: ____/____/____

Step 2: Member information

LAST Name: ____________________ FIRST Name: ____________________ Mid. Init. ______

Permanent Residence (Home) Street Address (P.O. Box is not allowed): ____________________

City: ____________________ State: _______ ZIP Code: _____ County: _______

Home Phone Number ( ): ____________________ Date of Birth: ____/____/____ Sex: □ M □ F

Mailing Address (only if different from your home address)

Street Address: ____________________

City: ____________________ State: _______ ZIP Code: _____

Email Address: ____________________

Step 3: Medicare card information

Please take out your Medicare card to complete this section.
- Please fill in these blanks so they match your red, white and blue Medicare card, OR
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.
You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Medicare Health Insurance

Name: ____________________ Medicare Claim #: ____________________

Is Entitled To: Hospital (Part A) ____/____/____ Medical (Part B) ____/____/____

Step 4: Primary Care Physician (PCP) - not required for GoldAnywhere PPO or USA Care PPO plans

Primary Care Physician (full name required): ____________________

Existing patient? □ Yes □ No
Step 5: Please read and answer these important questions

1. Are you the retiree?  □ Yes  □ No
   If yes, retirement date (month/day/year) ________________ If no, name of retiree ___________________________

2. Are you covering a spouse or dependents under this employer or union plan?  □ Yes  □ No
   If yes, name of spouse ________________________________ Names of dependents __________________________

3. Do you or your spouse work?  □ Yes  □ No

4. Do you have End Stage Renal Disease (ESRD)?  □ Yes  □ No
   If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker’s Compensation, VA benefits, EPIC (in New York) or V-Pharm (in Vermont).
   Will you have other prescription drug coverage in addition to MVP?  □ Yes  □ No
   If yes, refer to the ID card for your other drug coverage for the following information:
   Name of other coverage ________________________________
   Effective date ________________ Rx ID # __________
   Rx Group # __________ Rx BIN # __________ Rx PCN __________

6. Are you a resident in a long-term care facility, such as a nursing home?  □ Yes  □ No
   If “yes,” please provide the following information:
   Name of institution __________________________________ Phone number ___________________
   Address of institution (number and street) ______________________________

Step 6: Signature and Authorization

**Release of information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MVP will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above) this signature certifies that:
1) This person is authorized under State law to complete this enrollment, and
2) Documentation of this authority is available upon request from Medicare.

**PLEASE SIGN BELOW**

Signature ____________________________________________ Today’s date __________________

If you are the authorized representative, you must sign above and provide the following information:

Name __________________________________________________

Address __________________________________________________________________________

Phone number __________________________ Relationship to enrollee __________________________
Please contact MVP if you need this information explained to you in another language, or provided in a different format (Braille).

Our office hours are:
Monday - Friday, 8 am - 8 pm Eastern Time
From October 1 - February 14,
representatives are available every day from 8 am - 8 pm
1-800-324-3899
TTY: 1-800-662-1220

MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in MVP Health Plan depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Please return completed forms to:

Department of Human Resources
Rochester Institute of Technology
George Eastman Hall, 5th Floor
8 Lomb Memorial Drive
Rochester, NY 14623-5604

For Office Use Only

Previous ID #
Name of staff member/agent/broker (if assisted in enrollment):
Agent License #