



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)

Association Group # 251692

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

