OMB No. 0938-1378 Expires 12/31/2026

2026 Individual Enrollment Application

For MVP Health Care® Medicare Advantage Health Plans

MVP DualAccess Plans (HMO D-SNP)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

To join a Medicare Advantage Plan, you must also have both Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).

When do I use this form?

You can join a plan:

- October 15–December 7 each year (for coverage starting January 1)
- Within three months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your Medicaid Number (the number on your Medicaid card)
- Your permanent address and phone number

You must complete all items in Sections 1–7, unless otherwise noted.

Things you should remember.

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7
- If applicable, your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit

What happens next?

Send your completed and signed form to:

MVP DualAccess Plan Enrollment
MVP Health Care
20 S Clinton Ave
Rochester NY 14604-1793

Once MVP processes your request to join, they will contact you.

How do I get help with this form?

Call MVP Health Care at **1-800-324-3899**.
TTY users can call 711.

Or call Medicare at **1-800-MEDICARE** (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a MVP Health Care al **1-800-324-3899** (TTY 711), o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

MVP Health Plan, Inc. is an HMO-POS/PPO/HMO D-SNP organization with a Medicare contract and a contract with the New York State Medicaid program. Enrollment in MVP Health Plan depends on contract renewal.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR§§ 422.50, 422.60, 423.30, and 423.32 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Please complete Sections 1–7. Complete one enrollment application per applicant.

Please contact the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY 711) if you need information in a language other than English, or in an accessible format. Call seven days a week, 8 am–8 pm Eastern Time. April 1–September 30, call Monday–Friday, 8 am–8 pm.

Section 1: Select the Plan in Which You Want to Enroll

☐ **MVP DualAccess (HMO D-SNP)**	**$0** monthly premium
☐ **MVP DualAccess Complete (HMO D-SNP)**	**$0** monthly premium

Section 2: Information About Yourself *(please print)*

Name *(Last, First, Middle Initial)*

Sex ☐ **Male** ☐ **Female**

Date of Birth

Preferred Residence Street Address *(PO Box is not allowed)*

Phone No. ( )

City

State

Zip Code

County

Mailing Address *(if different from Permanent Address)*

City

State

Zip Code

MVP Member ID No. *(if a current MVP Medicare Member)*

Preferred Email Address *(optional)*

Do you want information sent to you in a language other than English?

☐ **Spanish** ☐ **Other:** _____

Are you enrolled in your State's Medicaid program?

☐ **Yes** (Your Medicaid No. _____) ☐ **No**

If you want to receive information from us in an accessible format, please indicate below your desired format.

☐ **Braille** ☐ **Large Print** ☐ **Audio CD** ☐ **Data CD**

If you need information in another format not listed above, call the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY 711).

Section 3: Your Medicare Number

The following can be found on your red, white, and blue Medicare card.

Your Medicare Number (XXXX-XXX-XXXX)

Effective Dates

Hospital (Part A)

Medical (Part B)

Member Name *Medicare Member ID No.*

Section 4: Your Primary Care Physician (PCP)

Primary Medical Group Name

PCP's Full Name

City

State

Zip Code

Are you an existing patient? ☐ **Yes** ☐ **No**

Section 5: Read and Provide Answers to the Following Questions *(please print)*

1. Will you have other prescription drug coverage in addition to MVP? ☐ **Yes** ☐ **No**
Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or EPIC (NY).
If you answered ***Yes***, refer to the ID card for your other drug coverage and provide the following:

Name of Other Coverage

Rx ID No.

Rx Group No.

Your answers to the following questions are optional.
You can't be denied coverage because you did not answer them.

2. Do you or your spouse work? ☐ **Yes** ☐ **No**

3. Have you served in the military? ☐ **Yes** ☐ **No**

Section 6: Reason for Enrolling

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period, October 15–December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. **Please read the following statements carefully and check the box if the statement applies to you.** By checking any of the following boxes, you are certifying that to the best of your knowledge, you are eligible for an Enrollment Period. If Medicare later determines that this information is incorrect, you may be disenrolled.

☐ This is my selection for Annual Enrollment.

☐ I am new to Medicare or I had Medicare before, but I am now turning 65.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period.

☐ I am leaving employer or union coverage on (date) _____.

☐ I belong to a pharmacy assistance program provided by my state, or EPIC (NY).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (date) _____.

☐ I recently had a change in my Medicaid (started receiving Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (started receiving Extra Help or lost Extra Help) on (date) _____.

Member Name *Medicare Member ID No.*

- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) on (date) _____.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (date) _____.
- ☐ My current plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (date) _____.
- ☐ I recently was released from incarceration. I was released on (date) _____.
- ☐ I recently obtained lawful presence status in the United States on (date) _____.
- ☐ I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility) on (date) _____.
- ☐ I recently left a PACE program on (date) _____.
- ☐ After living permanently outside of the United States, I recently returned to the U.S. on (date) _____.
- ☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA), or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ My current plan has been placed into receivership.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates.
- ☐ I was granted a Special Enrollment Period due to exceptional circumstances as determined by Medicare.
- ☐ I was enrolled in a plan that has been identified by CMS as a consistent poor performer in the Medicare Star Ratings.
- ☐ I am enrolling into a 5-star plan.
- ☐ None of these statements applies to me. Please contact MVP to see if you are eligible to enroll. Call **1-800-324-3899** seven days a week, 8 am–8 pm Eastern Time. April 1–September 30, call Monday–Friday, 8 am–8 pm. (TTY 711).

Section 7: Your Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent to the release, use, and disclosure of my information (which may include prescription information, medical information, HIV, mental health, and/or alcohol and substance abuse information) by MVP Health Care® (MVP) or any health care provider involved in caring for me to Medicare, MVP, or any health care providers, or organizations involved in my care, and other plans as is reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. I also acknowledge that MVP may release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

Member Name *Medicare Member ID No.*

*(**Section 7: Your Signature and Authorization** continued)*

By signing below, I understand that:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in an MVP Medicare Advantage Plan.
- By joining this Medicare Advantage Plan, I acknowledge that MVP will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on the cover page of this form).
- Your response to this form is voluntary. However, failure to respond may affect your enrollment in the plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- By providing my email address, I give permission for MVP to send me emails related to my plan and benefits. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **my.mvphealthcare.com** and selecting *Communication Preferences* or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).
- I understand that when my MVP Health Care coverage begins, I must get all of my medical and prescription drug benefits from MVP. Benefits and services provided by MVP and contained in my MVP Health Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MVP will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

Signature *Today's Date*

If you are the authorized representative, sign above and provide the information below about yourself.

Name	Relationship to Enrollee	Preferred Phone No. ( )	
Street Address	City	State	Zip Code

Member Name *Medicare Member ID No.*

Office Use Only

Name of Staff Member/Agent/Broker *(if assisted in enrollment)* | Plan ID No. | Effective Date of Coverage

ICEP/IEP | AEP | SEP (type) | Not Eligible | National Producer No. *(Agents/Brokers Only)*

Paperwork Reduction Act Disclosure Statement

According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Blvd, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on the cover page to send your completed form to the plan.

Language Assistance

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call **1-844-946-8010** (TTY 711).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al **1-844-946-8010** (TTY 711).	**Español (Spanish)**
请注意 : 您可以免费获得语言协助服务和其他辅助服务。请致电 **1-844-946-8010** (TTY 711)。	繁體中文 **(Chinese)**
ملاحظة: **1-844-946-8010** خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم (TTY 711).	**لعربية (Arabic)**
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다 **1-844-946-8010** (TTY 711). 번으로 연락해 주십시오.	한국어 **(Korean)**
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру **1-844-946-8010** (TTY 711).	Русский **(Russian)**
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il **1-844-946-8010** (TTY 711).	**Italiano (Italian)**
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le **1-844-946-8010** (TTY 711).	**Français (French)**
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele **1-844-946-8010** (TTY 711).	**Kreyòl Ayisyen (French Creole)**
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט **1-844-946-8010** (TTY 711).	**אידיש (Yiddish)**
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: **1-844-946-8010** (TTY 711).	**Polski (Polish)**
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa **1-844-946-8010** (TTY 711).	**Tagalog (Tagalog-Filipino)**
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। **1-844-946-8010** (TTY 711).-এ ফোন করুন।	**বাংলা** (Bengali)
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi **1-844-946-8010** (TTY 711).	**Shqip (Albanian)**
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο **1-844-946-8010** (TTY 711).	Ελληνικά **(Greek)**
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں **1-844-946-8010** (TTY 711). کریں	اردو **(Urdu)**

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