New York State Affidavit for Qualifying Event

Special Open Enrollment Period

STATE OF _____)

) ss.:

COUNTY OF _____)

Date of Qualifying Event ____/____/ 20____ **(MVP must receive notice and any premium payment due within 60 days of these events)**

The undersigned being duly sworn, deposes and says:

I seek to enroll in coverage in an individual insurance plan through MVP Health Plan, Inc. (MVP) outside of the annual Open Enrollment period (November 1–January 31). I am completing this Affidavit as a Subscriber (and on behalf of my Spouse or Child, if applicable) within 60 days of the occurrence of one of the following events (check all that apply):

- ☐ You, or Your Spouse or Child loses minimum essential coverage due to losing employer-based coverage, divorce, the end of an individual policy plan year, COBRA expiration, aging off a parent's plan, losing eligibility for Medicaid or Child Health Plus, and other similar circumstances. *(Voluntary termination or termination for non-payment does not qualify as a loss of coverage.)*
- ☐ You move and become eligible for new health plans.†
- ☐ You gain a Dependent or become a Dependent through marriage†, birth, adoption, or placement for adoption.
- ☐ You become pregnant (certification from doctor required for effective date eligibility; 60-day rule does not apply).
- ☐ You, Your Spouse, or Child exhausted Your COBRA or continuation coverage.

†*By signing this form, I attest that all qualified enrollees can demonstrate that they had minimum essential coverage as described in 26CFR 1.5000A-1(b) for one or more days during the 60 days preceding the qualifying event.*

This form must be Notarized if you are eligible for one of the following Qualifying Events:

- ☐ * Your enrollment or non-enrollment in another health plan was unintentional, inadvertent, or erroneous, and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the Exchange (needs to be Notarized).
- ☐ * You adequately demonstrate to MVP that another health plan in which You were enrolled substantially violated a material provision of its contract (needs to be Notarized).
- ☐ * You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions (needs to be Notarized).

("You" refers to the individual completing this Affidavit)

Through my signature below, I certify that I (and my Spouse and/or Child), if applicable, meet the guidelines to enroll in an individual plan through MVP based on the above qualifying event(s) that I have indicated apply. I declare that I have made this certification to the best of my knowledge and belief. Should I later learn or discover that one, or all, of the qualifying events was not true and correct, I will promptly notify MVP of this new information.

Name (print) Signature

Address Phone No.

For Notary Use: for items with an asterisk (*)

Sworn to before me this _____ day of _____ , 20 _____

Notary Public _____