MAKE SURE YOU GET YOUR ANNUAL CHECKUP AND PREVENTIVE CARE.

IT'S ON US!

PLEASE KEEP THE IMPORTANT DOCUMENTS YOUR METROPLUSHEALTH REPRESENTATIVE HAS GIVEN YOU, INCLUDING:

- ✓ Enrollment Documentation Page
- ✓ Your MetroPlusHealth Representative's contact information
- ✓ Member Portal Account Setup Instructions
- ✓ Your Plan's Brochure
- ✓ Conflict of Interest Form
- ✓ Rewards Program Brochure

IF YOU KNOW ANYONE THAT NEEDS HEALTH INSURANCE, YOU CAN REFER THEM BY:

- ✓ Calling your Representative
- ✓ Visiting metroplus.org

MetroPlus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MBR 23.218

MetroPlus Health

THANK YOU FOR CHOOSING US!

✓ THIS IS METROPLUSHEALTH.

SINCE 1985, METROPLUSHEALTH HAS HELPED NEW YORKERS FIND QUALITY HEALTH COVERAGE AT LOW COST.

Metro Plus Health

With over 34,000 providers, 40 hospitals, and 110 urgent care centers, more than 700,000 have chosen us for their care.

As a member, you will have access to these great values:

- ✓ Member Portal
- ✓ Over 34,000 Providers
- ✓ Rewards Program
- ✓ Urgent Care Centers
- ✓ Gym Reimbursement*

*Medicaid & CHP members are ineligible for this benefit.

Please immediately schedule your baseline / annual appointment with your Primary Care Physician (PCP) as soon as you are officially enrolled.

✓ IMPORTANT REMINDERS:

If you do not renew your coverage you will be disenrolled and lose your coverage. Normally, you have to renew every year. **Your renewal date is below.**

YOUR ESTIMATED COVERAGE PERIOD*:

_____ to _____

*** Please contact your MetroPlusHealth Representative 45 days before your coverage end date.**

Your Representative's name:

_____

Your Representative's Phone #:

_____

If you have a monthly premium and do not pay on time, you will be disenrolled and lose your coverage. You may also be liable for bills generated during the time you do not have coverage.

✓ OTHER IMPORTANT DETAILS:

Application Date: _____

Account # / HX #: _____

Product Selected: _____

Estimated Monthly Premium: $ _____

Requested Doctor (If applicable)**:**

_____

Number of Years Chosen for Automatic Renewal: _____

Anticipated Renewal Date: _____

Conditional Enrollment Information (If applicable)**:**

- Documents required for submission to the NY State of Health:

_____

_____

_____

_____

_____

_____

- Date Documents are Due to the NY State of Health: _____

Portal Username: _____

Portal Password: _____

Premium Paid: $ _____

_____ _____

Rep's Signature *Date*

_____ _____

Applicant's Signature *Date*