

# New York State Small Group Product Application

MVP Health Plan, Inc. | MVP Health Insurance Company | MVP Health Services Corp.



## Section 1: Group Information *(please include Company Name and Tax ID No. on pages 2 and 3)*

Company Name		SIC Code	Tax ID No. <i>(required)</i>
Street Address		Phone Number ( )	Fax Number ( )
City	State	Zip Code	County
Group Contact Name		Group Contact Title	Phone Number ( )
Group Contact Email (this person will receive an MVP online account login)			Fax Number ( )
Additional Office Locations			
Group Effective Date	Group Type <input type="checkbox"/> Employer Group or Employer Trust <input type="checkbox"/> Association or Chamber <input type="checkbox"/> Taft Hartley Trust <input type="checkbox"/> Labor Union <input type="checkbox"/> Member of Controlled Group or Corporation <input type="checkbox"/> Multiple Employer Trust		

## Section 2: Billing Contact Information *(please print)*

Same as Group Contact above *(proceed to Section 3)*

Billing Contact Name		Billing Contact Title	Phone Number ( )	
Street Address		City	State	Zip Code
Billing Contact Email			Fax Number ( )	

## Section 3: Other Group Contact Information *(if applicable)*

Contact Name		Contact Title		
Contact Email		Phone Number ( )		
Contact Name		Contact Title		
Contact Email		Phone Number ( )		

## Section 4: Product Selection

<input type="checkbox"/> Platinum Plan No. _____	<input type="checkbox"/> Medicare Gold	<input type="checkbox"/> MVP Dental PPO for Adults
<input type="checkbox"/> Gold Plan No. _____	<input type="checkbox"/> Silver 4 with Embedded HRA	<input type="checkbox"/> MVP Dental PPO for Families
<input type="checkbox"/> Silver Plan No. _____	<input type="checkbox"/> Healthy NY	<input type="checkbox"/> MVP Dental for Kids Plan*
<input type="checkbox"/> Bronze Plan No. _____	<input type="checkbox"/> Dependent through Age 29	<input type="checkbox"/> Delta Dental PPO Plan*
	<input type="checkbox"/> Unlimited Skilled Nursing	<input type="checkbox"/> Other

Desired Effective Date

\_\_\_\_\_

\* If you have purchased this Affordable Care Act (ACA) required benefit through another carrier, please complete Section 8 on page 2.

Company Name \_\_\_\_\_

Tax ID No. \_\_\_\_\_

### Section 5: Group Administration

Total number of employees including full-time<sup>1</sup>, part-time equivalent<sup>2</sup>, seasonal equivalent<sup>2</sup>, and 1099 employees \_\_\_\_\_

Retirees and COBRA participants are not considered “employees” and should not be used to determine group size.

New hire eligibility policy:  Date of hire  First day of the month following date of hire

First day of the month following \_\_\_\_\_ day(s) of employment (may not exceed 90 days)

<sup>1</sup> The “full-time equivalent” (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size. This method is the same calculation used to determine employer liability under the “Shared Responsibility for Employers” provisions of the Affordable Care Act (ACA) and Internal Revenue Code.

<sup>2</sup> To convert the number of part-time employees to a full-time equivalent, the aggregate number of hours worked for part-time employees is divided by 120. Part-time hours are capped at 120 hours per employee per month.

### Section 6: Other Group Coverage in Addition to MVP

1. Name of Other Carrier \_\_\_\_\_ Effective Date of Policy \_\_\_\_\_

Type of Coverage and Plan Design (metal level) \_\_\_\_\_

2. Name of Other Carrier \_\_\_\_\_ Effective Date of Policy \_\_\_\_\_

Type of Coverage and Plan Design (metal level) \_\_\_\_\_

### Section 7: Enrollment Class/Subgroup

Class Description (example: All employees working more than 20 hours per week) \_\_\_\_\_

Does your group need a separate class/subgroup assigned for one of the following?

Medicare  COBRA  Hourly  Salary  Union  Other \_\_\_\_\_

### Section 8: Stand-Alone Dental Coverage

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NY State of Health™ Marketplace-certified, stand-alone dental plan offered outside the NY State of Health Marketplace?  Yes  No

If you answered yes, please provide the name of the company issuing the stand-alone dental coverage. \_\_\_\_\_

If you answered no, MVP will provide you with pediatric dental essential health benefit coverage.

### Section 9: Certification

To the best of my knowledge, all the statements/responses in this application are true and complete. By signing this application, I certify that under penalty of perjury, that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business.

#### Insurance Fraud Statement

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Company Name

Tax ID No.

**Section 10: Broker Information** *(please print)*

Broker Name		Firm Name		
Street Address	City	State	Zip Code	Phone Number ( )
Email				Fax Number ( )

**Section 11: Private Exchange Information**

Is this group to be enrolled through a private exchange (other than the NY State of Health Marketplace)?  Yes  No

If Yes, please provide the name of the private exchange. \_\_\_\_\_

**Section 12: MVP Representative Information** *(please print)*

The information provided in this application is true to the best of my knowledge.

Was a Broker involved in this sale?  Yes MVP Broker No. \_\_\_\_\_  No

Print Name

Signature	Date
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Questions? We're here to help.



Call **1-800-TALK-MVP** (825-5687)



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