New York State Small Group Product Application

Please complete all three pages of this form.

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

Company Name | SIC Code | Tax ID No *(required)*

Street Address | Phone No. ( ) | Fax No. ( )

City | State | Zip Code | County

Group Contact Name | Group Contact Title | Group Contact Phone No. ( )

Group Contact Email | Group Contact Fax No. ( )

Additional Office Locations

Group Effective Date

Group Type

☐ Employer Group or Employer Trust ☐ Association or Chamber ☐ Taft Harley Trust ☐ Labor Union

☐ Member of Controlled Group or Corporation ☐ Multiple Employer Trust

Section 2: Billing Contact Information

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

Billing Contact Name | Billing Contact Title | Billing Contact Phone No. ( )

Street Address | City | State | Zip Code

Billing Contact Email | Billing Contact Fax No. ( )

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

Contact Name | Contact Title

Contact Email | Phone No. ( )

Contact Name | Contact Title

Contact Email | Phone No. ( )

Section 4: Product Selection

☐ Platinum Plan No.
☐ Gold Plan No.
☐ Silver Plan No.
☐ Bronze Plan No.

☐ Medicare Gold
☐ Silver 4 with Embedded HRA
☐ Dependent through Age 29
☐ Unlimited Skilled Nursing

☐ MVP Dental PPO® for Adults
☐ MVP Dental PPO® for Families
☐ MVP Dental PPO for Kids®
☐ Delta Dental PPO Plan

Continued on page 2

Company Name	*Tax ID No.*

Section 5: Group Administration

Total Number of Part-Time and Full-Time Employees Over the Prior Calendar Year *(to determine Certification of Benefits for members 66 and older)*	Total Number of Full-Time Equivalent Employees[1] Over the Prior Calendar Year *(to determine if Small or Large Group)*

Note: Retirees and COBRA participants are not considered "employees" and should not be counted to determine group size.

[1] 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.

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.

New Hire Eligibility Policy ☐ Date of hire ☐ First of the month following date of hire

☐ First of the month following _____ day(s) of employment (may not exceed 90 days)

Section 6: Separate Entities with Multiple Tax ID Numbers

Only complete this section if you have separate entities with multiple Tax ID numbers.

Group size for groups under common ownership is determined based upon the total Full-Time Equivalent Employees (FTEs) for all entities. In order to combine separate groups into one employer group for group insurance purposes, MVP will require documentation showing 80% of each entity is owned by the same person or set of people.

Please check if any of the following conditions apply:

☐ Multiple Tax ID numbers are listed above ☐ This/These groups are owned by another entity

☐ This group owns another entity ☐ This group is one of multiple groups that are owned by the same entity/entities

If any of the above conditions apply, tax documentation certifying that at least 80% common ownership must be submitted. Acceptable tax forms are (1) IRS Form 851 (Affiliations Schedule) with names of all entities or (2) Schedule K-1 (IRS Form 1065).

Section 7: Other Group Coverage in Addition to MVP

1	Name of Other Insurer	Type of Coverage and Plan Design *(metal level)*	Effective Date of Policy
2	Name of Other Insurer	Type of Coverage and Plan Design *(metal level)*	Effective Date of Policy

Section 8: Enrollment Class/Subgroup Assignment

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

Select a separate Class/Subgroup, if your Group requires one:

☐ Medicare ☐ Salary ☐ COBRA ☐ Union ☐ Hourly ☐ Other _____

Section 9: Authorization

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

By including an email address on this Enrollment/Change form, I agree to accept electronic communication unless otherwise required by law.

Any person who knowingly and with 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 five thousand dollars and the stated value of the claim for each violation.

I have read and agree to this authorization.

Signature Date

Name *(print)* Title

Continued on page 3

Company Name	*Tax ID No.*

Section 10: Broker Information

Broker Name	Firm Name		
Street Address	City	State	Zip Code
Billing Contact Email	Phone No. ( )	Fax No. ( )	

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

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

Name *(print)* Signature Date

_____

Was a Broker involved in this sale? ☐ Yes MVP Broker No. _____ ☐ No