Healthy NY Small Group Product Application

Please complete all pages of this form.

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

Group/Business Name or DBA Name *(if applicable)* | SIC or NAICS Code *(required)* | Tax ID No. *(required)*

Legal Entity Name *(If different than Group Name)* | Nature of Business or Organization

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

City | State | Zip Code

Company Headquarters Street Address ☐ *Same as above* | Phone No. ( ) | Fax No. ( )

City | State | Zip Code

Group Health Benefits Administrator (HBA) Name | Group HBA Title | Group HBA Phone No. ( )

Group HBA Email

Group HBA Street Address ☐ *Same as Company Headquarters Above* ☐ *Same as Group Physical Address Above*

City | State | Zip Code

Additional Office Locations (Include full address)

Effective Date of Coverage

Who sponsors the group health coverage? *(check one)*

☐ Employer ☐ Union ☐ Association ☐ Other: _____

Organization Type ☐ C Corp ☐ S Corp ☐ Partnership ☐ Nonprofit ☐ Local Government ☐ State Government ☐ Church Group ☐ Trust ☐ Other: _____

List Owner(s)/Partner(s) of this Organization

Section 2: Billing Contact Information

☐ Premium invoices should be sent to the HBA Contact and Address listed in Section 1 *(proceed to Section 3)*.

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

Street Address | City | State | Zip Code

Billing Contact Email

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Group Name | *Tax ID No.*

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

Contact Name | Contact Title

Contact Email | Contact Phone No. ( )

Section 4: Regulatory Information/Eligibility Requirements

1 Within the last 12 months, has your business provided health insurance that included both medical and hospital benefits (other than Healthy NY) to the class of employees that you are looking to cover? ☐ Yes ☐ No

2 **If yes**, did your business contribute more than $50 per employee per month toward the premium (or $75 if the business is located in Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk or Westchester counties)? ☐ Yes ☐ No

3 Do at least 30% of the employees who will be offered coverage earn annual wages of $43,000 or less? ☐ Yes ☐ No

4 Will your business contribute at least 50% of the Healthy NY premium on behalf of covered employees? ☐ Yes ☐ No

5 Will your business offer Healthy NY coverage to all employees working 20 hours or more per week who earn annual wages of $43,000 or less? ☐ Yes ☐ No

6 Will at least 50% of the class of employees who are offered Healthy NY coverage through your business actually enroll or have health insurance through another source? ☐ Yes ☐ No

7 Will at least one employee be earning annual wage of $43,000 or less enroll in Healthy NY? ☐ Yes ☐ No

8 Does your group have fewer covered employees outside the MVP service area than covered employees within the MVP service area? ☐ Yes ☐ No

Section 5: Group Administration

Total Number of Part-Time and Full-Time Employees Over the Prior Calendar Year
(To determine Coordination of Benefits for members 65 and older)

Total Number of Full-Time Equivalent Employees[1] Over the Prior Calendar Year
(To be eligible for Healthy NY coverage, the business must have had a total of 50 or fewer FTE employees over the prior calendar year.)

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 _____ 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).

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Group Name | *Tax ID No.*

Section 7: Small Business Health Options Program (SHOP) Attestation

Have you completed the New York State SHOP eligible employer verification process and found that the Group named on page 1 of this application is SHOP eligible? ☐ Yes ☐ No

Section 8: Other Group Coverage in Addition to MVP

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

Section 9: Enrollment Class/Subgroup Assignment

Class Description ☐ Active
(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 10: Pediatric Dental Essential Health Benefit

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 of the NY State of Health Marketplace? ☐ Yes ☐ No

If ***Yes***, please provide the name of the company issuing the stand-alone dental coverage.

If ***No***, MVP will provide you coverage of the pediatric dental essential health benefit *(select one)*, as required by the Affordable Care Act.

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

Section 11: Additional Rider/Product Options

Riders ☐ Dependent through Age 29 ☐ Coverage for Domestic Partners **Dental** ☐ MVP Dental PPO® for Adults

Section 12: Authorization *(Your signature is required for Enrollments)*

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

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I have read and agree to the details outlined in MVP's Electronic Disclosure, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (825-5687).

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.

Name *(print)* Title

Signature Date

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Group Name	*Tax ID No.*

Section 13: Broker Information

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

Section 14: 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