

Please complete and submit all pages of this form.

Section 1: Group Information *(please print)*

Group Name			Group Number
Federal Tax ID No.	Federal Tax ID No.	Federal Tax ID No.	Federal Tax ID No.

If you are paying 100% of your employees' premiums, all employees must enroll in coverage under New York State Insurance Law §4235(c)(1)(A) (McKinney Supp. 2010).

Provide a complete list of the names of the owners of this company, even if some owners are not taking coverage.

1 Name	2 Name
3 Name	4 Name

Section 2: Group Administration Details

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 Employees* 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.

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.

*The full-time equivalent (FTE) employee counting method in 26 U.S. Code § 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.

Does at least one employee taking coverage live, work, or reside in the MVP regional service area? Yes No
Contact your broker or MVP Account Representative if you are unsure which states and counties are covered within the MVP regional service area.

Does your group have more enrolled employees within the MVP regional service area than outside of it? Yes No

Section 3: Regulatory Information/Eligibility Requirements

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

Do at least 30% of the employees who will be offered coverage earn annual wages of \$44,075 or less? Yes No

Section 4: Separate Entities with Multiple Tax ID Numbers *(only complete this Section if this applies to your Group)*

Group size for groups under common ownership is determined based upon the total Full-Time Equivalents for all entities. In order to combine separate groups into one employer group for group insurance purposes, MVP will require documentation that 80% of each entity is owned by the same individual or set of people. Check if any of the following conditions apply:

- | | |
|--|--|
| <input type="checkbox"/> Multiple Tax ID Numbers are listed in Section 1 | <input type="checkbox"/> This/These groups are owned by another entity |
| <input type="checkbox"/> This group owns another entity | <input type="checkbox"/> 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 with this Recertification. Acceptable tax forms are: (1) IRS Form 851 (Affiliations Schedule) with the names of all entities or (2) IRS Form 1065 (Schedule K-1).

Group Name	Group No.
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Section 5: Group Contact Information

Physical Street Address		City	State	Zip Code
County	Phone No.			
Mailing Street Address		<input type="checkbox"/> Same as Physical Address	City	State
County	Phone No.			

Health Benefits Administrator Name	Health Benefits Administrator Email
Billing Contact Name	Billing Contact Email
Broker/Agency Name	

Section 6: Business Locations

Include all business locations, even if located outside of New York State.

1 Street Address		City	State	Zip Code
County	Phone No.			
2 Street Address		City	State	Zip Code
County	Phone No.			
3 Street Address		City	State	Zip Code
County	Phone No.			
4 Street Address		City	State	Zip Code
County	Phone No.			

Section 7: Small Business Health Options Program (SHOP) Attestation *(response is required)*

Have you completed the New York State SHOP eligible employer verification process and found that the Group named in Section 1 of this form is SHOP eligible? Yes No

Group Name

Group No.

Section 8: Authorization

For a group health plan to be considered a “group health plan” under the Employee Retirement Income Security Act (ERISA), there must be at least one common law employee enrolled as a contract holder. Pursuant to 29 CFR 2510.3-3(b), an “employee benefit plan” does not exist if no “employees” are covered by the plan. An “employee” does not include the owner(s) of a business or a spouse of the business owner.

*Employer
Initials* _____ By signing this document, you attest that your group has made MVP Health Care coverage available to all common law employees and that at least one common law employee is currently enrolled with one of your group sponsored health plans for the term of the benefit year. Please note that waivers of coverage, including spousal waivers, cannot be used to determine group eligibility.

*Employer
Initials* _____ MVP reserves the right to request your group’s tax documents at any time throughout the year. Failure to produce requested documents could result in the termination of your group health insurance.

*Employer
Initials* _____ I certify that, to the best of my knowledge and belief, and under penalty of perjury, the information listed on this form is true and complete, including that the persons proposed for coverage work at least 20 hours per week or are otherwise eligible for coverage.

*Employer
Initials* _____ I understand that 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 \$5,000 and the stated value of the claim for each such violation.

Employer Signature

Date

Employer Name (print)

Title

Please fax all pages of this completed form and any required documents to 518-836-3279.