MVP Health Plan, Inc.

Healthy NY Small Group Recertification

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 Sate 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 $45,450 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:

☐ **Multiple Tax ID Numbers are listed in Section 1**
☐ **This group owns another entity**
☐ **This/These groups are owned by 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 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).

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Group Name *Group No.*

Section 5: Group Contact Information

Physical Street Address | City | State | Zip Code

County | Phone No.

Mailing Street Address ☐ *Same as Physical Address* | City | State | Zip Code

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**

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Group Name *Group No.*

Section 8: MVP Vision Plan Attestation

Complete only if your group is enrolled in an MVP vision plan.

Employer Initials _____	If MVP vision plan(s) are offered with non-voluntary rates, you attest that the employer contribution is 80% or more to the vision premium.

Section 9: 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 return all pages of this completed form and any required documents by fax to 518-836-3279 or email to SBIU@mvphealthcare.com.