

For Small Businesses & Working Individuals

**HEALTHY NY**

[www.HealthyNY.com](http://www.HealthyNY.com)

**HEALTHY NY APPLICATION FOR**

# Individuals and Sole Proprietors

*There has never been a better time  
to buy health insurance.*



**State of New York**  
David Paterson, Governor

**New York State Insurance Department**  
Eric R. Dinallo, Superintendent

**1-866-HEALTHY NY (1-866-432-5849) • [www.HealthyNY.com](http://www.HealthyNY.com)**

## INSTRUCTIONS

### Healthy NY Application for Individuals and Sole Proprietors

*Confidentiality Statement: Information provided on this application will remain confidential and will only be disclosed to the staff at health plans and state agencies operating this program.*

#### SECTION A: Applicant Information

In this section, we ask how to contact you.

#### SECTION B: Coverage Options

##### 1. Benefits

Healthy NY offers a standardized benefit package with an optional limited prescription benefit. Choose if you want Healthy NY with a limited prescription drug benefit (yearly limit of \$3,000, \$100 deductible) or without a prescription drug benefit. Once you choose whether or not you want prescription drug coverage, you will not be able to change your selection until your annual recertification or if your premium rate changes.

##### 2. Deductible

Choose if you want a yearly deductible or a plan with no deductible. Once you choose whether or not you would like a deductible, you will not be able to change your selection until your annual recertification.

The deductible option has a lower premium. The deductible is \$1,150 for individuals and \$2,300 for families (more than one person). Except for preventive care, you must pay for the cost of covered services until you meet the deductible. You can access preventive care before meeting the deductible and will have a co-payment for these services. Co-payments do not apply towards the deductible.

The deductible option qualifies as a High Deductible Health Plan (HDHP) that is designed to be used with a health savings account (HSA). This is a savings account used to pay for qualified medical expenses. Contributions are tax-deductible, and money in the account can earn interest tax-free. You can contribute up to \$2,850 for individual coverage and \$5,650 for family coverage into the account in 2009.

**You should carefully consider all options before making a decision.** Visit [www.HealthyNY.com](http://www.HealthyNY.com) for more information.

#### SECTION C: Employment Information

To be eligible for Healthy NY, either you or your spouse must have worked at some point within the past 12 months. Please answer the employment questions.

#### SECTION D: Health Insurance Information

Healthy NY is for people who have been without comprehensive health insurance for 12 months **or** who have lost their health insurance due to certain specific events. Please answer the questions in Section D regarding prior health insurance coverage. Canceling other insurance due to cost does not entitle you to coverage.

#### SECTION E: Household Income

In order to qualify for Healthy NY, your household income must fall within the limits set by law. Please list your current gross (before tax) monthly income and the current gross monthly income of your spouse (if residing in your household). No one else's income is counted. Income includes wages, salary, self-employment income, interest and dividends, Social Security income, retirement income, alimony, unemployment benefits and workers' compensation. Do not include foster care income, public assistance, Supplemental Security Income, or child support received.

HEALTHY NY 2009 INCOME GUIDELINES	
FAMILY SIZE	MONTHLY GROSS HOUSEHOLD INCOME
1	Up to \$2,257
2	Up to \$3,036
3	Up to \$3,815
4	Up to \$4,594
5	Up to \$5,373
Each Additional Person	Add \$780

Effective 1/09. Pregnant women count as 2.

#### SECTION F: Household Members

Please complete the chart in Section F. Include information for yourself, your spouse and your children. If you are a sole proprietor, you may include information about your domestic partner, if applicable. Spouses and domestic partners must reside in your household. Do not count other people residing in your household such as parents, roommates, etc.

#### SECTION G: Documentation

Documentation of NYS residence, employment status and household income must be included with your application. Submit documentation of current income such as your most recent pay stubs. You must include documentation that shows your income for the last month. If this information is not available or not representative of your normal income, submit your tax return or business documentation and provide an explanation of the documentation.

#### SECTION H: Certification

Please carefully review and complete the certification set forth in Section H.

### SUBMITTING YOUR APPLICATION

Send your completed application directly to the HMO or participating insurer that you choose. For a list of HMOs and participating insurers and their addresses and rates, go to [www.HealthyNY.com](http://www.HealthyNY.com) and select the link "HMOs and Rates by County." Applicants whose completed applications are received by the 20th of the month may be enrolled by the 1st of the following month. For faster processing, include a check for the first month's premium, made out to the HMO or participating insurer. If you have other questions, or to check the status of your application, please call your chosen HMO or participating insurer directly.

# Healthy NY Application

## For Individuals and Sole Proprietors

### SECTION A: Applicant Information

Mr.  Mrs.  Miss  Ms.

Male  Female

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

#### Street Address of person applying for coverage:

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

#### Mailing Address if different than street address:

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

### SECTION B: Coverage Options

#### Benefits

1. Please choose whether or not you want prescription drug coverage. The premium for prescription drug coverage is more expensive. There is a \$3,000 per person annual prescription drug benefit maximum.

Yes  No

#### Deductible

2. Would you like Healthy NY coverage with a deductible? Except for preventive care, you must pay for the cost of covered services until you meet the deductible. Healthy NY with a deductible has a lower premium.

Yes  No

### SECTION C: Employment Information

1. Please indicate whether you are applying as an individual or as a sole proprietor. *A sole proprietor is someone who is the sole owner and only employee of a business, regardless of the business' format.*

Individual

Sole Proprietor – You will be asked to submit proof of self-employment

2. You can qualify for Healthy NY if either you or your spouse has worked during the past 12 months. Please answer the following questions about employment:

Who is currently employed?  You  Spouse  Neither

Who has worked in the past 12 months?  You  Spouse  Neither

*If both questions above are answered "Neither," then you will not qualify for Healthy NY.*

## SECTION D: Health Insurance Information

Healthy NY is available to individuals who have not had comprehensive (medical **and** hospital) health insurance coverage in place during the past 12 months **or** have lost their insurance due to certain reasons. Please answer the following questions to assist us in determining your eligibility.

1. Have you had health insurance coverage that included both medical and hospital benefits during the past 12 months? *Note: Answer "Public Program" if your coverage was through Medicaid, Child Health Plus, Family Health Plus, Healthy NY, or another public health program.*

Yes

No

Public Program

Name of Public Program \_\_\_\_\_

2. If you have had comprehensive health insurance coverage during the past 12 months, Please indicate the reason(s) for termination. *Please check all that apply.*

Loss of employment

Change to a new employer

Change of residence

Death of a family member

Legal separation, divorce or annulment

Reaching the maximum age under your policy

Loss of eligibility for group health insurance coverage

Discontinuation of a group health insurance plan

Termination or cancellation of COBRA/continuation coverage

3. Date coverage terminated or will terminate due to reason noted in 2.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## SECTION E: Household Income

Income limitations are set by law. Please list your current monthly **gross** income and the current monthly **gross** income of your spouse (if residing in your household). Gross income is before taxes. Please include wages, salary, interest and dividends, self-employment income, Social Security income, retirement income, alimony, unemployment benefits and workers' compensation. Please **do not** include foster care income, public assistance, Supplemental Security Income, or child support received.

Applicant's Current Monthly Gross Income \$ \_\_\_\_\_

Spouse's Current Monthly Gross Income \$ \_\_\_\_\_

**TOTAL** \$ \_\_\_\_\_

**Note: Sole proprietors may deduct their documented monthly business expenses in calculating monthly income.**

## SECTION F: Household Members

The household income limitation depends upon the number of household members that you have. Household members include yourself, your spouse (if residing in the household) and dependent children. For each person listed, please indicate whether that person is applying for coverage. Sole proprietors may include a domestic partner, if they want coverage for the domestic partner under the policy. Fill in the name of the primary care physician chosen by each person to be covered, if known.

<b>Applicant's Name (First, MI, Last)</b>	<b>Date of Birth</b>	<b>Applying for Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Social Security Number</b>
	<b>Name of Primary Care Physician (if known):</b>		
<b>Spouse's or Domestic Partner's Name (First, MI, Last)</b>	<b>Date of Birth</b>	<b>Applying for Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Social Security Number</b>
	<b>Name of Primary Care Physician (if known):</b>		
<b>Child's Name (First, MI, Last)</b>	<b>Date of Birth</b>	<b>Applying for Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Social Security Number</b>
	<b>Name of Primary Care Physician (if known):</b>		
<b>Child's Name (First, MI, Last)</b>	<b>Date of Birth</b>	<b>Applying for Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Social Security Number</b>
	<b>Name of Primary Care Physician (if known):</b>		
<b>Child's Name (First, MI, Last)</b>	<b>Date of Birth</b>	<b>Applying for Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Social Security Number</b>
	<b>Name of Primary Care Physician (if known):</b>		
<b>Child's Name (First, MI, Last)</b>	<b>Date of Birth</b>	<b>Applying for Coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Social Security Number</b>
	<b>Name of Primary Care Physician (if known):</b>		

Pregnant women count as two people for determining household size. Are any of the household members listed above pregnant?

No     Yes    (Name \_\_\_\_\_)

Are any of the household members eligible for Medicare? Medicare is federal health insurance for people of all incomes. It is usually for people ages 65 and older and people who are disabled.

No     Yes    (Name \_\_\_\_\_)

## SECTION G: Documentation

You must attach documentation of NYS residence, employment within the past 12 months for you or your spouse, and your household income. Documentation should match your statements in earlier sections of the application. You must include documentation that shows your entire current monthly income, such as pay stubs for an entire month. Note that one document can fulfill more than one category. Please check the boxes below that show which types of documentation you are submitting.

<b>NYS RESIDENCE</b> <b>(should match Section A)</b>	<b>EMPLOYMENT</b> <b>(should match Section C)</b>	<b>HOUSEHOLD INCOME</b> <b>(should match Section E)</b>
<input type="checkbox"/> NYS driver license <input type="checkbox"/> Utility bill (gas, electric, cable, etc.) or postmarked mail with address <input type="checkbox"/> Letter/lease/rent receipt from landlord <input type="checkbox"/> Property tax records or mortgage statement <input type="checkbox"/> Other (explain): _____	<input type="checkbox"/> Pay stubs <input type="checkbox"/> Letter from employer <input type="checkbox"/> Documentation sufficient to demonstrate self-employment <input type="checkbox"/> Other (explain): _____ _____ _____	<input type="checkbox"/> Pay stubs <input type="checkbox"/> Award letters/benefit checks <input type="checkbox"/> Business records <input type="checkbox"/> Letter from employer <input type="checkbox"/> Other (explain): _____ _____ _____

## SECTION H: Certification

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true to the best of my knowledge. I further certify that I am ineligible for health insurance provided by my employer and all individuals to be covered are ineligible for Medicare.

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 five thousand dollars and the stated value of the claim for each such violation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Important Information About Pre-Existing Conditions

A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months. Your Healthy NY policy will exclude coverage for that condition for **up to 12 months**. However, this period may be **reduced or eliminated** if you are transferring from other health insurance coverage which terminated no more than **63 days** prior to the date that you submit your Healthy NY application. Please review your Healthy NY health insurance policy and the Healthy NY guidebook or contact your health plan for a full explanation of what is considered a pre-existing condition and how this restriction may affect you.

The 12-month exclusion period mentioned above is shorter if you have been determined to be eligible under the Federal Trade Adjustment Act of 2002. Please notify your HMO.

## Selecting Your Health Plan

An important step in applying for Healthy NY is choosing the health plan which will provide your coverage. Healthy NY is offered by all HMOs and some other health plans in New York State. The Healthy NY benefit packages are the same regardless of which health plan you choose.

You must pay a monthly premium for Healthy NY. Keep in mind that even though Healthy NY benefits are the same at each health plan, the Healthy NY premiums do vary. To obtain current premium rates please contact your local health plan.

For helpful information to compare health plans, visit [www.ins.state.ny.us](http://www.ins.state.ny.us) to view the NYS Insurance Department's *Consumer Guide to Health Insurers* and the *Interactive Consumer Guide to HMOs* or call the NYS Insurance Department Resource Center toll-free at 1-800-342-3736 to obtain copies of the publications.

## Where to Send Your Application

To apply, submit your application directly to the health plan of your choice. For fastest processing, include a check for the first month's premium made out to the health plan. To obtain the names, addresses and telephone numbers of the health plans in your area visit the Healthy NY Web site at [www.HealthyNY.com](http://www.HealthyNY.com) or call toll free 1-866-HealthyNY (1-866-432-5849).

## Additional Information:

Healthy NY has a separate program for qualifying small employers who wish to offer health insurance to their employees. If your employer wants to learn more about this separate program, have them call toll-free 1-866-HEALTHY NY (1-866-432-5849) or log onto [www.HealthyNY.com](http://www.HealthyNY.com).

Child Health Plus is a health insurance program for children. If you are eligible for Healthy NY, it is likely that your children will qualify for Child Health Plus at a reduced premium. If so, it may be to your advantage to cover your children through Child Health Plus. For more information call toll-free 1-800-698-4543.

Family Health Plus is a reduced cost health insurance program for adults. It is available to adults at lower income levels than Healthy NY. If you are eligible, it may be to your advantage to enroll in Family Health Plus. For more information call toll-free 1-877-9FHPLUS.

# Here is What Healthy NY Enrollees Have to Say:

*"I am very grateful for Healthy NY.  
Without it, health insurance would  
not be affordable for me."*

*"Healthy NY is one of the most  
important services in my life.  
I have been without insurance for 5 years...  
I work very hard but don't  
make a lot of money."*

*"Finally something for workers who  
don't have health insurance  
through their employment."*

*"Healthy NY allows us to do what we  
love and still be covered.  
Thank you and I hope you keep it up."*



David Paterson, Governor  
State of New York

Eric R. Dinallo, Superintendent  
New York State Insurance Department

**[www.HealthyNY.com](http://www.HealthyNY.com)**  
1-866-HEALTHYNY (1-866-432-5849)

May 2007