# Healthy NY Product Application

## New York State Small Groups

MVP Health Care, 625 State Street, Schenectady NY 12305-2111. Call **1-844-865-0250** or visit **mvphealthcare.com**.
***Please complete all pages of this form. Include the Group Name and Group Tax ID No. on all pages.***

### Section 1: Group Information *(please print)*

**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 | City | State | Zip Code

Phone No. ( ) | Fax No. ( )

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

Phone No. ( ) | Fax No. ( )

**Group** Health Benefits Administrator (HBA) Name | **Group** HBA Title

**Group** HBA Email | **Group** HBA Phone No. ( )

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

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** Email | **Billing Contact** Phone No. ( )

**Billing Contact** Street Address | City | State | Zip Code

*Continued on page 2*

*Group Name* *Group 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

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

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

Do at least 30% of the employees who will be offered coverage earn annual wages of $51,570 or less? ○ Yes ○ No

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

Will your business offer Healthy NY coverage to all employees working 20 hours or more per week who earn annual wages of $51,570 or less? ○ Yes ○ No

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

Will at least one employee be earning annual wage of $51,570 or less enroll in Healthy NY? ○ Yes ○ No

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

Solely for purposes of determining whether an employer is a large or small employer, the employer is required to calculate the number of Full-Time Equivalents (FTE) it employed **during the most recent rolling 12 months**, and count each such FTE as one full-time employee. Refer to the employee definitions below.

**Common Law Employees** are eligible for health Insurance coverage. Common law employees are defined as anyone who performs services for an employer as long as the employer has financial and/or behavioral control for these employees. Leased employees, 1099 employees, and union employees are considered employees under this definition and should be included in the group size count.

**Retirees** are not "employees" and are not counted in group size.

**Part-Time Employees** are those who work less than 30 hours per week and are counted using the FTE counting method. To convert the number of part-time employees to an FTE number, the average monthly 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.

**COBRA** participants are not included in the FTE calculation for determining group size.

To assist you in calculating your group's part-time FTEs, visit **irs.gov/affordable-care-act** and select *Employers*, then *Determining if an Employer is an Applicable Large Employer.*

| **Total Number of Full-Time Employees** | + | **Total Number of Part-Time FTE* Employees** | = | **Total Number FTE Employees** |
|---|---|---|---|---|
| | | | | |

*The full-time equivalent 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.

**New Hire Eligibility Policy** ☐ Date of hire ☐ First of the month following _____ day(s) of employment *(may not exceed 90 days)*

*Continued on page 3*

*Group Name* *Group Tax ID No.*

## 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 Equivalents (FTE) for all entities. To combine separate groups into one employer group for group insurance purposes, the commonly owned businesses or affiliates must qualify as a single employer under subsection (b), (c), (m) or (o) of the Internal Revenue section 414.

If any of the following conditions apply, tax documentation certifying that at least 80% common ownership may be required upon request.

**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**, MVP may, at its discretion require the employer to submit documentation demonstrating common ownership under section 414.

## 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.

☐ Delta Pediatric Dental PPO

## Section 11: Additional Rider/Product Options

**Riders** ☐ Dependent through Age 29 ☐ Coverage for Domestic Partners

**Vision** ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

*Continued on page 4*

*Group Name* *Group Tax ID No.*

## 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** (1-800-825-5687). I understand I can opt out of electronic communication at any time by contacting MVP Healthcare.

**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

## 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**

**Questions? We're here to help.** Call **1-844-865-0250** Or visit **mvphealthcare.com**