HMO Plans 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. Some sections may not apply to your group.

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

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

Legal Entity Name *(if different than Group Name)* | SIC Code *(required)*

Nature of Business or Organization | **Effective Date of Coverage**

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

City | State | Zip Code | County

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

City | State | Zip Code | County

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

Group HBA Email | Group HBA Phone No. ( )

Group HBA Street Address ☐ *Same as above* | City | State | Zip Code

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

Are the owners and their spouses the only policy holders on the group sponsored coverage? ☐ Yes ☐ No

This company is organized as: ☐ Stand Alone ☐ Parent ☐ Subsidiary ☐ Local Plant/Office/Division ☐ Other: _____

Do you, as an employer, offer a group medical plan in addition to the products offered through MVP Health Care®? ◯ **Yes** ◯ **No**

If ***Yes***, who is the plan carrier?

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Company Name | *Tax ID No.*

Section 2: Billing Information

☐ *Premium invoices should be sent to the Group 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** Fax No.
	( )	( )

Billing Street Address	City	State	Zip Code	County

Section 3: Regulatory Employer Information

Do you employ at least one employee who lives, works, or resides in the MVP service area?	◯ Yes ◯ No
Are all employees who are offered coverage working at least 20 hours per week?	◯ Yes ◯ No
Is there at least one common law employee enrolled as a contract holder?	◯ Yes ◯ No
Does your group have fewer covered employees outside the MVP service area than covered employees within the MVP service area?	◯ Yes ◯ No
If owners are enrolling in MVP coverage, do they all work at least 20 hours per week?	◯ Yes ◯ No

Section 4: 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.at 120 hours per employee per month.

New Hire Eligibility Policy

☐ Date of hire ☐ First of the month following date of hire

☐ First of the month following _____ day(s) of employment *(may not exceed 90 days)*

Continued on page 3

Company Name *Tax ID No.*

Section 5: Enrollment Class/Subgroup Assignment

Class Description *(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 6: Product Selection

☐ Platinum Plan No. ____________
☐ Gold Plan No. ____________
☐ Silver Plan No. ____________
☐ Bronze Plan No. ____________
☐ Medicare Gold

☐ Silver 4 with Embedded HRA
☐ Dependent through Age 29
☐ Unlimited Skilled Nursing

☐ Delta Dental Pediatric PPO Plan
☐ MVP Vision 1
☐ MVP Vision 2
☐ MVP Vision 3

Section 7: Information About Individuals Not Listed on NYS-45-ATT or Other State Equivalent

Please list below the individuals eligible for coverage who are not listed on the NYS-45-ATT, *Quarterly Combined Withholding, Wage Reporting, and Unemployment Insurance Return form*, or other state equivalent. Eligible individuals include partners or owners of the business if actively engaged in the business, COBRA/New York State continuants, new employees, retirees, and spouses of retirees when it is the consistent policy of the business owner to cover retirees and spouses of retirees.

The group attests that the individual(s) listed below work at least 20 hours per week at the employer named on page 1 or are otherwise eligible for coverage under a group health insurance plan to be issued by MVP. For each employee listed, indicate their employment status.

Name

☐ New Employee *(Date of hire: ____________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ____________________

Name

☐ New Employee *(Date of hire: ____________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ____________________

Name

☐ New Employee *(Date of hire: ____________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ____________________

Name

☐ New Employee *(Date of hire: ____________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ____________________

Name

☐ New Employee *(Date of hire: ____________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ____________________

Name

☐ New Employee *(Date of hire: ____________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ____________________

Section 8: 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.

Please check if any of the following conditions apply:

☐ Multiple Tax ID numbers are listed above
☐ 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, MVP may, at its discretion require the employer to submit documentation demonstrating common ownership under section 414.

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Company Name *Tax ID No.*

Section 9: 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 10: Broker Information

☐ *I understand that the agency below may be entitled to a base and/or bonus compensation for our business. This broker information will remain in effect until we notify MVP Health Care otherwise.*

Broker Name	Agency Name		
Street Address	City	State	Zip Code
Billing Contact Email	Phone No. ( )	Fax No. ( )	

Section 11: Private Exchange Information

Is this group to be enrolled through a private exchange (other than the NY State of Health Marketplace)? ◯ Yes ◯ No

If ***Yes***, please provide the name of the private exchange: _____

Section 12: MVP Representative Information

The information provided in this application is true to the best of my knowledge.

MVP Representative Name (print) *Signature* *Date*

Section 13: Authorization

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.

Signature *Date*

Name (print) *Title*