HIP®
HEALTH PLAN OF NEW YORK

HEALTHY NEW YORK APPLICATION for INDIVIDUALS and SOLE PROPRIETORS

Section A. Application Information *(please tell us who you are and how to contact you)*

Name: First | M.I. | Last

Home Telephone | Work Telephone | E-Mail Address:

Street Address (of person applying for health insurance) | Apt #

City | State | Zip | County

Billing Address (if different than the street address)

City | State | Zip | County

MARITAL STATUS: ☐ Single ☐ Married ☐ Legally Separated/Divorced

Date of Event: (mo/date/year) ____ / ____ / ____

IN CASE OF EMERGENCY, PLEASE CONTACT: Name ______ Relationship ______

Telephone No: (Home) ______ (Work) ______

TYPE OF APPLICATION: Please indicate whether you are applying as an individual or as a sole proprietor (someone who is the sole owner and only employee of a business). Please see instructions for further information. ☐ Individual ☐ Sole Proprietor

Benefit Package. The premiums are different for each benefit package.

☐ Healthy NY coverage only
☐ Healthy NY with prescription drug coverage (max $3,000 per person annually)
☐ Healthy NY with High Deductible Health Plan Coverage (HDHP)
☐ Healthy NY with Prescription Drug Coverage and a High Deductible Health Plan coverage (HDHP)

(Please note that future changes between HDHP Plans and standard Healthy NY Plans may only be made at the time of recertification.)

Section B1. Household Members *(please tell us about yourself, your legal spouse (or domestic partner if you are a Sole Proprietor) if residing in the household or any dependent children eligible for coverage). No one else is to be counted. The household income limitation depends upon the number of household members that you have. For each person listed, please indicate whether that person is applying for coverage.*

	List Below All Eligible Family Members (include self) (Last Name, First Name & Social Security #)	Sex	Date of Birth Mo.	Day	Yr.	Eligible For Medicare	Insurance Company*	Policy Number*	Type of Coverage*	Effective Dates*	Applying For Coverage
SELF	NAME SS NO. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F				☐ YES ☐ NO				FROM TO	☐ YES ☐ NO
SPOUSE / DOMESTIC PARTNER	NAME SS NO. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F				☐ YES ☐ NO				FROM TO	☐ YES ☐ NO
CHILD	NAME SS NO. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F				☐ YES ☐ NO				FROM TO	☐ YES ☐ NO
CHILD	NAME SS NO. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F				☐ YES ☐ NO				FROM TO	☐ YES ☐ NO

(After each member row:)

PRIMARY CARE PHYSICIAN: ☐ Internal ☐ Family Practice ☐ Pediatrics
Physician Name ______ Physician ID Number ______

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Physician Name ______ Physician ID Number ______

List Below All Eligible Family Members (include self) (Last Name, First Name & Social Security #)	Sex	Med. Group Network Physician	Date of Birth Mo.	Day	Yr.	Eligible For Medicare	Insurance Company*	Policy Number*	Type of Coverage*	Effective Dates*	Applying For Coverage
CHILD NAME SS NO. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F					☐ YES ☐ NO				FROM TO	☐ YES ☐ NO
PRIMARY CARE PHYSICIAN: ☐ Internal ☐ Family Practice ☐ Pediatrics Physician Name ______ Physician ID Number ______											
CHILD NAME SS NO. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ M ☐ F					☐ YES ☐ NO				FROM TO	☐ YES ☐ NO
PRIMARY CARE PHYSICIAN: ☐ Internal ☐ Family Practice ☐ Pediatrics Physician Name ______ Physician ID Number ______											

**** If your spouse and/or dependents have other Health Insurance please provide information above.***

Pregnant women count as two people for determining household size.
Are any of the household members listed above pregnant? ☐ **NO** ☐ **YES (how many?)** ______

Section B2. Household Income

Please list your current monthly gross income and the current monthly gross income of your spouse (if residing in your household). 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 public assistance, supplemental security income (SSI), foster care payments or child support payments.

Applicant's Current Monthly Gross Income	$
Spouse's Current Monthly Gross Income	$

(Please Note: Sole Proprietors should deduct their monthly business expenses in calculating their monthly income.)

Section C. Health Insurance Information

Generally, Healthy New York coverage is available to people who do not currently have and have not had health insurance for 12 months. However, there are exceptions - such as if your other coverage provides limited benefits, if your coverage terminated due to certain reasons, or if your other coverage is one that is eligible for transfer to Healthy New York. See the instructions for additional information.

Please answer the following questions regarding health insurance coverage in the space provided. Most questions can be answered with a simple 'Yes" or "No"

1. Do you currently have health insurance coverage which includes both medical and hospital benefits?
(see instructions) ☐ Yes ☐ No

2. Have you had health insurance coverage during the past twelve months? ☐ Yes ☐ No

(Note: Answer "No" if your coverage was through Medicaid, Child Health Plus, Family Health Plus or another public program or if you had Cobra coverage)
(if no, skip question number 4)

3a. If you have had health insurance coverage during the past twelve months, did it terminate for one of the following reasons? *(check all that apply)*
☐ Loss of employment
☐ Death of a family member resulting in termination of coverage
☐ Change to a new employer which does not provide coverage
☐ Change of residence

3a. ***(continued)***

- ☐ Discontinuation of a group health insurance plan
- ☐ Legal separation, divorce or annulment
- ☐ Loss of eligibility for group health insurance coverage
- ☐ Loss of coverage due to reaching the maximum age of dependency
- ☐ Termination or Cancellation of COBRA/continuation coverage

3b. Date coverage terminated or will terminate due to reason noted above. ___________________________

4a. Are you eligible for health insurance through your employer? ☐ Yes ☐ No

4b. Does your employer contribute towards the cost of the health insurance? ☐ Yes ☐ No

Section D. Employment

You can qualify for Healthy NY if you or your spouse worked during the past year. Please answer the following questions about employment.

Is currently employed	☐ You	☐ Spouse	☐ Neither
Has worked in the past year	☐ You	☐ Spouse	☐ Neither

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

Section E. Documentation

You need to attach 3 types of documentation. These include documentations of employment status, documentation of NYS residence and documentation of income.

Examples of Acceptable Documentation *(You need only one for each category)*:

Employment Status	NYS Residence	Income
• **Pay Stubs** • **W-2s forms** • **Letter From Employer** • **Documentation sufficient to demonstrate self-employment** • **Other (please explain)**	• **Utility Bill** • **Postmarked Mail With Address** • **Letter/Lease/Rent Receipt with Home Address from Landlord** • **NYS Driver's License** • **Property Tax Records or Mortgage Statement** • **Other (please explain)**	• **Pay stubs** • **W-2s forms** • **Letter From Employer** • **Business Records** • **Award letters/benefit checks** • **Other (please explain)**

* **Income documentation must cover an entire month and should reflect current income.**

YOU MAY ALSO NEED TO SHOW PROOF OF OTHER ITEMS

Individuals who are transferring from other public programs should attach proof of participation in these programs in addition to the documentation listed above.

Section F. Certification

1. I am applying for direct payment coverage for myself, my spouse, and any eligible dependents as prescribed by law. I elect to enroll myself and my family members, if any, with the Medical Group/Network Physician named above.
2. I understand that this application is subject to acceptance and assignment of an effective date by HIP and all information furnished in this application is true and complete to the best of my knowledge.

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 that 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 ____________________

Your completed application must be forwarded with your check or money order to:

HIP HEALTH PLAN OF NEW YORK
P.O. Box 2793
New York, NY 10116-2793

1. I understand that pre-existing conditions will not be covered during the first 12 months of the contract. A Pre-existing Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. HIP will credit the time I/we were covered by the previous policy, provided that the break in coverage between the prior plan and coverage under this plan does not exceed sixty-three (63) days, exclusive of any waiting periods. I agree that after enrolled, I will upon request provide HIP and/or my medical group with information on pre-existing conditions(s) and any previous coverage I had.

   Subject to the applicable State and Federal laws pertaining to pre-existing conditions and creditable coverage, benefits for pre-existing conditions may not be payable for up to twelve months from the effective date of the contract.

Federal Trade Adjustment Act of 2002
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.

2. On behalf of myself and each eligible family member, I hereby authorize all health care providers who have rendered any service to any of us, to furnish to HIP and our Medical Group/Network Physician, at any time upon request all medical information for the purposes of processing claims or managing care.

TO BE COMPLETED BY HIP	DATE RECEIVED:	EFFECTIVE DATE:	PROCESSED BY: