

Section A. Small Employer Applicant Information

Complete the following by printing or typing the requested business information in the spaces provided.

Company Name	Date		
Street Address			
City	State	Zip	County
Mailing Address (if different)			
City	State	Zip	County
Company Officer's Name	Title		
Contact Person	Title		
Telephone No.	Fax No. (if available)		

Benefit Package. The benefit package is chosen by the employer and will be the same for all of your employees. The premiums are different for each benefit package.

- | | |
|---|---|
| <input type="checkbox"/> Healthy NY coverage only | <input type="checkbox"/> Healthy NY with High Deductible Health Plan Coverage (HDHP) |
| <input type="checkbox"/> Healthy NY with prescription drug coverage (max \$3,000 per person annually) | <input type="checkbox"/> 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. In addition, Small Groups who select a HDHP must enroll the entire Small Group, and individual members of the group are not allowed choose an alternate plan.)

Section B. Health Insurance Information

Please answer each question in the space provided. Most questions can be answered with a simple "Yes" or "No."

Healthy NY is for small businesses which are currently unable to provide their employees with comprehensive health insurance coverage. Healthy NY is generally not available to employers who are already providing their employees with health insurance coverage.

Please answer the following questions to assist us in determining your eligibility to purchase Healthy NY.

1. Within the last twelve months, has your business provided comprehensive group health insurance for your employees?
(Answer "Yes" only if the coverage included both medical and hospital coverage.)
(Answer "Yes" only if your business contributed toward the premium.)
 Yes No
2. If the answer to question 1 is "Yes," did your business contribute more than [\$50] (or [\$75] if the business is located in the Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk and Westchester counties) per employee per month toward the cost of the health insurance?
 Yes No

Section C. Eligibility Requirements

Healthy NY includes certain eligibility requirements designed to reach those small businesses most in need. Please answer the following questions about your business.

Please note that you must be able to check “Yes” to each question in this section in order to be eligible to purchase Healthy NY.

1. Does your business have 50 or fewer employees?

Yes No

(If no how many employees does your business have?) _____

2. Do at least 30% of the employees who will be offered coverage earn annual wages of \$36,500 or less?

Yes No

3. Will your business contribute at least 50% of the Healthy NY premium on behalf of your full-time employees?

Yes No

(If no what percentage?) _____

4. Will your business offer Healthy NY coverage to all employees working 20 hours or more who earn annual wages of \$36,500 or less?

Yes No

Section D. Participation Requirements

Healthy NY has certain employee participation requirements. Please answer these questions about who will be accepting coverage in Healthy NY.

Please note that you must be able to check “Yes” to each question in this section in order to be eligible to purchase Healthy NY.

1. Will at least 50% of the employees who are offered Healthy NY coverage through your business actually accept enrollment or have health insurance through another source?

Yes No

2. Will at least one employee earning annual wages of \$36,500 or less enroll in Healthy NY?

Yes No

Section E. Employee Information

1. Employers may offer Healthy NY coverage to their employee’s dependents. Employers are not required to contribute towards the Healthy NY premium for dependents. Will your business be offering Healthy NY coverage to the dependents of your employees?

Yes No

(*dependents includes spouses, domestic partners and children.)

2. Participating employers may choose to offer Healthy NY coverage to part-time workers. Will your business be offering Healthy NY coverage to part-time workers who work less than 20 hours weekly?

Yes No

(*Businesses do not need to contribute to the cost of premiums for employees who work less than 20 hours per week.)

Section F. Employer Certification

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer of the business and that I am duly authorized to execute this certification on behalf of the business.

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

Print Name

Title

Date

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

HIP HEALTH PLAN OF NEW YORK-Healthy New York Program
P.O. Box 2806
New York, NY 10116-2806