



HEALTH PLAN OF NEW YORK

HEALTHY NEW YORK RE-CERTIFICATION FOR SMALL EMPLOYERS

Section A. Small Employer Information

Please print or type the requested business information in the spaces provided.

Healthy New York Identification Number (if known) _____ Date _____

Company Name _____

Street Address _____

City _____ State _____ Zip _____ County _____

Telephone No. _____ Fax No. _____

Contact Person _____ Title _____ Telephone No. _____

Section B. Information About Insurance Coverage

- Will the business continue to contribute at least 50% of the Healthy NY premium on behalf of the employees?
 Yes No
- Will the business be offering Healthy NY coverage to dependents of its employees?
 Yes No
- Healthy NY is available with coverage for prescription drugs or without prescription drug coverage. Healthy NY is also available with High Deductible Health Plan Coverage (HDHP). You may change benefit plans only at the time of annual recertification. The benefit plan will be the same for all employees. Choose the benefit plan below. 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 (up to \$3,000 per person annually)	<input type="checkbox"/> Healthy NY with Prescription Drug Coverage and a High Deductible Health Plan (HDHP)

Section C. Eligibility Requirements

- Important:** In order to meet eligibility requirements, the business must have fifty or fewer eligible employees. Half of the employees offered Healthy NY coverage must enroll in the program and at least 30% of the employees offered coverage must earn \$36,500 or less in annual wages. At least one employee earning \$36,500 or less must actually enroll in the program. The business must offer coverage to all employees working 20 or more hours weekly who earn \$36,500 or less annually. The business may offer coverage to part-time workers.

of eligible employees _____

enrolled in Healthy NY _____

of eligible employees earning \$36,500 or less in annual wages _____

of enrolled employees earning \$36,500 or less in annual wages _____

Section C. Eligibility Requirements (continued)

2. Are there any Medicare eligible employees on this plan?

Yes

No

If so, please provide the employees name (First, MI, Last), gender, and Social Security Number.

Section D. 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 the business meets the eligibility requirements outlined in Section C. I further certify that I am an officer of the business and 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.

Print name of officer completing certification

Signature

Title

Date