

(Date)

(Mr./Mrs.) BA last name)

(Street Address)

(City, State, ZIP)

Dear (Mr./Mrs. BA Last name):

We regret to inform you that we cannot offer your group HIP Healthy New York coverage at this time. The reason(s) are as follows:

- Your application is incomplete.* _____
- The supporting documentation required to determine your group's eligibility did not accompany your application.* _____
- Your group is ineligible because you have provided, and contributed 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, group health insurance coverage to your employees within the twelve-month period preceding this group application.
- Your group is ineligible because you, as an employer, do not contribute at least 50% of the Healthy New York premium on behalf of each covered full time employee.
- Your group is ineligible because you have over 50 eligible employees.
- Your group is ineligible because at least 30% of your eligible employees do not earn \$36,500 or less.
- Your group is ineligible because at least one person earning \$36,500 or less does not participate.
- Your group is ineligible because your place of business is not located in New York State.
- Other: _____

If you have questions about our decision, you may write to: New Business Marketing Department
Attention: Healthy New York, HIP Health Plan of New York, P.O. Box 2806, New York, NY 10116-2806.

If you wish to appeal this decision, you may write to: NYS Insurance Department, Consumer Services – Healthy NY, One Commerce Plaza, 20th Floor, Albany, NY 11257.

Thank you.

Sincerely,

Marketing and Sales

** Please send your missing information or documentation along with this letter within 30 days of the date listed above to: New Business Marketing Department, Attention: Healthy New York, HIP Health Plan of New York, P.O. Box 2806, New York, NY 10116-2806.*