Healthy NY Application Instructions

Confidentiality Statement: The information provided on this application will remain confidential and will only be disclosed to the staff at health plans and state agencies operating this program.

Section A: Small Business Information

In this section, we ask how to contact you. Your business must be located in New York State in order to participate.

Section B: Eligibility Requirements

The business must employ 50 or fewer FTE employees, as explained in Section C, and be able to answer "Yes" to each question in Section D, to be eligible.

Section C: Insurance Information

Healthy NY is available to small business employers who have not provided comprehensive health insurance to their employees during the last 12 months. If you provided health benefits within the last 12 months, your business may still qualify if:

- Your business provided only "limited" health insurance benefits. (not comprehensive coverage)
- Your business did not contribute more than $50 per employee per month towards the premium (or $75 if the business is located in Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, or Westchester counties).
- The coverage was offered through Healthy NY.
- Your business has a class of employees that you have not offered health insurance to during the last 12 months but would now like to cover. The class must pertain to geographic location or employees' earnings, method of payment, hours, or job duties.

Section D: Participation Requirements

In order to be eligible, your business must meet the participation rules concerning employees who will purchase Healthy NY.

Section E: Employee Information

Please answer the questions in Section F about your employees who will be enrolling in Healthy NY.
You do not need to include information about their dependents. If necessary, photocopy the chart and attach additional sheets.

Section F: Certification

The certification must be completed by a duly authorized officer of the business.

Submitting Your Application

Please mail all information to:

Excellus Health Plan, Inc.
Attn: Small Business Sales Department
165 Court Street
Rochester, NY 14647

If you have any questions or need assistance completing the form, please contact your account service representative.

Healthy NY Application for Small Businesses

Section A: Small Business Information

Company Name: _____

Telephone: (____) _____ Fax: (____) _____

Street Address of Business: _____

City: _____ State: _____ Zip: _____ County: _____

Contact Person: _____ Title: _____

Telephone: (____) _____ Today's Date: _____

Section B: Employer Size Requirements

To be eligible for Healthy NY coverage, the business must have a total of 50 or fewer FTE (full-time equivalent) employees. The business may offer Healthy NY to a limited class of its employees, but the business cannot have more than 50 FTE employees overall. For more information on how to determine the number of FTE employees your business has, please see the Frequently Asked Questions at http://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm

How many total FTE employees does your business employ?

❑ 50 or fewer total FTE employees ❑ More than 50 total FTE employees (not eligible)

Section C: Insurance Information

You may offer Healthy NY to all of your employees or a class of your employees if you have not offered health insurance to them in the last 12 months. Please answer the following questions to assist us in determining your eligibility to purchase Healthy NY.

1. Within the last 12 months, has your business provided health insurance that included both medical and hospital benefits (other than Healthy NY) to the class of employees that you are looking to cover? ❑ Yes ❑ No

2. If the answer to question 1 above is "Yes," did your business contribute more than $50 per employee per month towards the premium (or $75 if the business is located in Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, or Westchester counties)? ❑ Yes ❑ No

If the answers to both questions 1 and 2 above are "Yes," then your business is not eligible for Healthy NY.

Section D: Eligibility Requirements

Eligibility requirements were 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. Do at least 30% of the employees who will be offered coverage earn annual wages of $41,250 or less? ❑ Yes ❑ No

2. Will your business contribute at least 50% of the Healthy NY premium on behalf of covered employees? ❑ Yes ❑ No

3. Will your business offer Healthy NY coverage to all employees working 20 hours or more per week who earn annual wages of $41,250 or less? ❑ Yes ❑ No

Section E: Participation Requirements

Please answer these questions about who will be accepting Healthy NY coverage. 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 class of 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 $41,250 or less enroll in Healthy NY? ❑ Yes ❑ No

Section F: Employee Information

1. Employers may offer Healthy NY coverage to their employees' dependents, including spouses, domestic partners, and children. 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

2. Employers may choose to make Healthy NY available to their part-time workers (those who work less than 20 hours weekly). You do not have to contribute towards the premiums for part-time workers. Will your business be offering Healthy NY coverage to part-time workers? ❑ Yes ❑ No

Section G: Employee Information (continued)

Complete the following information for each employee who is applying for coverage.
Please photocopy and attach additional sheets, if needed

Employee Name (First, MI, Last)	**Is this employee eligible for Medicare? (Yes or No)**

Section H: Certification

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true and accurate to the best of my knowledge. I further certify 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.

Print name of person completing certification

Signature

Title (must be owner or officer of business)

Date

If a broker assisted you with completing this application, he or she may be eligible for a commission paid by the HMO or insurer. Please complete the information below:

Broker's Name

License #

Company

Address

Phone

E-mail

Send your completed application

Please mail all information to:

Excellus Health Plan, Inc.
Attn: Small Business Sales Department
165 Court Street
Rochester, NY 14647

If you have any questions or need assistance completing the form, please contact your account service representative.

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For Internal Use Only

HIOS ID#: 78124NY1110009-00

EC: SGL1

Group Health Insurance Application/Change Form

- Please print clearly and complete all sections that apply to you
- Additional instructions are included
- This application cannot be processed without this information and a signature

Section 1: Employer Group Information

This section should be completed by the Group Benefits Administrator

Medical Group Number (8 digits) _____ Medical Subgroup Number (4 digits) _____ Medical Class Number (4 digits) _____

Dental Group Number _____ Dental Subgroup Number _____

Employer Name _____ Association/Chamber Name (if applicable) _____

Group Administrators Signature _____ Date _____

Subscriber Status:

Date of Hire: ___ /___ /____

☐Rehire- Date of Rehire: ___ /___ /____ ☐Retired - Effective Date: ___ /___ /____

☐COBRA - Effective Date: ___ /___ /____ ☐Cancelled -- Effective Date: ___ /___ /____

Please indicate reason for COBRA if applicable:

☐Left Employment/Retired ☐Divorce/Legal Separation ☐Loss of Student Status ☐Death of Subscriber

☐Dependent Reached Max Age ☐ Other: _____

Section 2: Your Information

This section should be completed by the Subscriber

Last Name _____ First Name _____ MI _____ Social Security # _____

Birthdate ___ /___ /____ Sex: Male ☐ Female ☐

Street Address _____ City _____ State _____ Zip _____

Phone _____

Email _____ Would you like to receive emails about health & wellness? ☐ Yes No☐

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

Medicare Number (if applicable) _____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced/Marital Status Event Date ___/___/_____

Section 3: Subscriber Medical Plan Selection

Healthy New York EPO

If enrolling in a Medical plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren)

☐Self & Spouse/Domestic Partner ☐Family

Effective Date: ___/___/_____

Section 4: Subscriber Dental Plan Selection

Please select plan if applicable:

☐Dental Blue Classic (DI) ☐Dental Blue Options (DJ)

☐Dental Other (DE)

If enrolling in a Dental plan, who do you need coverage for?

☐Self Only ☐Self & Child (ren)

☐Self & Spouse/Domestic Partner ☐Family

Medical & Dental Effective Date: __/___/___

Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

Section 5: Please indicate the reason for this enrollment or change

☐New Hire / Rehire ☐Open Enrollment ☐Retirement ☐Loss of Coverage ☐COBRA

☐Medicare Eligible ☐Change in employment status ☐Change to new employer that does not offer insurance

☐Loss of eligibility through employer or discontinuation of employer coverage

☐Marital Status Change ☐Marriage ☐Divorce ☐Dependent reaches maximum age of coverage

☐Address Change ☐Last Name Change ☐A move in or out of service area

☐Remove Dependent ☐Death

☐Add Dependent: Please indicate reason ☐Newborn ☐Marriage ☐Other _____

Date of Event ___/___/_____

Section 6: If canceling coverage, who are you canceling coverage for?

☐Subscriber

☐Medical Cancellation Date ___/___/_____ ☐Dental Cancellation Date ___/___/_____

☐Dependent(s) (List each dependent below in section 8)

☐Medical Cancellation Date ___/___/_____ ☐Dental Cancellation Date ___/___/_____

Why are you canceling coverage?

☐Subscriber's request ☐Divorce ☐Deceased ☐Medicare/Medicaid or other coverage

☐Coverage through spouse ☐Loss of eligibility through employer or discontinuation of employer coverage

☐Other _____

Section 7: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child *Separate form required

☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____

Last Name (if different) First Name MI Social Security #

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____

Last Name (if different) First Name MI Social Security #

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: Male ☐ Female ☐ Birthdate ___/___/_____

_____ _____ _____

Last Name (if different) First Name MI Social Security #

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

☐Dependent Child ☐Disabled Dependent Child*Separate form required ☐Other_____

Sex: M ☐ F ☐ Birthdate ___/___/_____

_____ _____ _____

Last Name (if different) First Name MI Social Security #

Medicare Eligible ☐Yes ☐No If yes, indicate reason ☐Age 65+ ☐Disability ☐End Stage Renal

_____ Part A Effective Date: ___/___/____ Part B Effective Date: ___/___/____

Medicare Number (if applicable)

Note: Use an additional application if more than four people need coverage.

Section 8: Other coverage information (Must be completed – you may be contacted for additional information)

Are you or any member of your family enrolled in other coverage? ☐Yes ☐No

If yes, are you keeping the coverage? ☐Yes ☐No

If no, when will the coverage cancel? __/__/__

Policyholder's name _____ ID# _____

Effective Date: ___/___/____

Who did the insurance cover? ☐Self Only ☐Self & Child(ren)
☐Self & Spouse/Domestic Partner ☐Family

Section 9: Release – You must sign and date this form to be eligible for health insurance.

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)
I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

PREFERRED PROVIDER ORGANIZATION (PPO)
I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.
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 $5,000 and the stated value of the claim for each such violation.

Subscriber Signature_____ **Date**_____

Please return to PO Box 22999, Rochester, NY 14692. If you have questions, please contact your Group Administrator.
Or, visit us at: ExcellusBCBS.com

Instructions for completing the Group Health Insurance Application

Section 1
This section should be completed by a Group Benefits Administrator.

Section 2
This section should be completed by the Subscriber.

Section 3
Column A – This column is populated with the plan name your group has selected.
Column B – Select who you want to cover on this medical plan.

Section 4
Column A – Select the dental plan your employer offers. All products may not be applicable to your employer group. Please check with your Group Administrator.
Column B – Select who you want to cover on this dental plan.

Section 5
Select the box that describes what you need to do regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you must also check coverage type and persons to be covered, and Dependent Information section.

You may be required to provide documentation of certain events.

Section 6
If you are canceling coverage, select who you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling.

Section 7
Please include information about all the people who you would like coverage for.
Use an additional application if more than four people need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.
Qualified guidelines for coverage include:

- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child (ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age. Please contact your Group Administrator for the appropriate form.

Section 8
Please include accurate information in this section. This could affect the processing of your application and/or claims.