EPO/PPO Plans Product Application
for New York State Small Groups

Please complete all pages of this form. Some sections may not apply to your group.

Section 1: Group Information *(please print, and include Company Name and Tax ID No. on pages 2 and 3)*

Group/Business Name or DBA Name *(if applicable)* | Tax ID No. *(required)*

Legal Entity Name *(if different than Group Name)* | SIC Code *(required)*

Nature of Business or Organization | **Effective Date of Coverage**

Business Physical Street Address | Phone No. ( ) | Fax No. ( )

City | State | Zip Code | County

Company Headquarters Street Address ☐ *Same as above* | Phone No. ( ) | Fax No. ( )

City | State | Zip Code | County

Group Health Benefits Administrator (HBA) Name | Group HBA Title

Group HBA Email | Group HBA Phone No. ( )

Group HBA Street Address ☐ *Same as above* | City | State | Zip Code

Who sponsors the group health coverage? *(check one)* ☐ Employer ☐ Union ☐ Association ☐ Other: _____

Organization Type ☐ C Corp ☐ S Corp ☐ Partnership ☐ Nonprofit ☐ Local Government ☐ State Government ☐ Church Group ☐ Trust ☐ Other: _____

List Owner(s)/Partner(s) of this Organization

Are the owners and their spouses the only policy holders on the group sponsored coverage? ☐ Yes ☐ No

This company is organized as: ☐ Stand Alone ☐ Parent ☐ Subsidiary ☐ Local Plant/Office/Division ☐ Other: _____

Do you, as an employer, offer a group medical plan in addition to the products offered through MVP Health Care®? ☐ Yes ☐ No

If ***Yes***, who is the plan carrier?

Continued on page 2

Company Name	*Tax ID No.*

Section 2: Billing Information

☐ Premium invoices should be sent to the Group Contact and Address listed in Section 1 *(proceed to Section 3)*.

Billing Contact Name	Billing Contact Title

Billing Contact Email	Billing Contact Phone No. ( )

Billing Street Address	Billing Contact Fax No. ( )

City	State	Zip Code	County

Section 3: Regulatory Employer Information

Do you employ at least one employee who lives, works, or resides in the MVP service area?	☐ Yes	☐ No
Are all employees who are offered coverage working at least 20 hours per week?	☐ Yes	☐ No
Is there at least one common law employee enrolled as a contract holder?	☐ Yes	☐ No
Does your group have fewer covered employees outside the MVP service area than covered employees within the MVP service area?	☐ Yes	☐ No
If owners are enrolling in MVP coverage, do they all work at least 20 hours per week?	☐ Yes	☐ No

Section 4: Group Administration

Total Number of Part-Time and Full-Time Employees Over the Prior Calendar Year *(to determine Certification of Benefits for members 65 and older)*	Total Number of Full-Time Equivalent Employees[1] Over the Prior Calendar Year *(to determine if Small or Large Group)*

Note: Retirees and COBRA participants are not considered "employees" and should not be counted to determine group size.

[1] The *full-time equivalent* (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size. This method is the same calculation used to determine employer liability under the *Shared Responsibility for Employers* provisions of the Affordable Care Act (ACA) and Internal Revenue Code.

To convert the number of part-time employees to a full-time equivalent, the aggregate number of hours worked for part-time employees is divided by 120. Part-time hours are capped at 120 hours per employee per month.

New Hire Eligibility Policy

☐ Date of hire ☐ First of the month following date of hire

☐ First of the month following _____ day(s) of employment *(may not exceed 90 days)*

Section 5: Enrollment Class/Subgroup Assignment

Class Description *(example: All employees working more than 20 hours per week)*

Select a separate Class/Subgroup, if your Group requires one:

☐ Medicare ☐ Salary ☐ COBRA ☐ Union ☐ Hourly ☐ Other: _____

Section 6: Product Selection

☐ Platinum Plan No. _____

☐ Gold Plan No. _____

☐ Silver Plan No. _____

☐ Bronze Plan No. _____

☐ Medicare Gold

☐ Silver 4 with Embedded HRA

☐ Dependent through Age 29

☐ Unlimited Skilled Nursing

☐ MVP Dental PPO® for Adults

☐ MVP Dental PPO® for Families

☐ MVP Dental PPO for Kids®

☐ Delta Dental Pediatric PPO Plan

Continued on page 3

Company Name	*Tax ID No.*

Section 7: Information About Individuals Not Listed on NYS-45-ATT or Other State Equivalent

Please list below the individuals eligible for coverage who are not listed on the NYS-45-ATT, *Quarterly Combined Withholding, Wage Reporting, and Unemployment Insurance Return form*, or other state equivalent. Eligible individuals include partners or owners of the business if actively engaged in the business, COBRA/New York State continuants, new employees, retirees, and spouses of retirees when it is the consistent policy of the business owner to cover retirees and spouses of retirees.

The group attests that the individual(s) listed below work at least 20 hours per week at the employer named on page 1 or are otherwise eligible for coverage under a group health insurance plan to be issued by MVP. For each employee listed, indicate their employment status.

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Name

☐ New Employee *(Date of hire: ______________________)*
☐ Partner ☐ Business Owner ☐ Retiree ☐ COBRA
☐ Other *(explain)* ______________________

Section 8: Separate Entities with Multiple Tax ID Numbers

Only complete this section if you have separate entities with multiple Tax ID numbers.

Group size for groups under common ownership is determined based upon the total Full-Time Equivalent Employees (FTEs) for all entities. In order to combine separate groups into one employer group for group insurance purposes, MVP will require documentation showing 80% of each entity is owned by the same person or set of people.

Please check if any of the following conditions apply:

☐ Multiple Tax ID numbers are listed above
☐ This/These groups are owned by another entity
☐ This group owns another entity
☐ This group is one of multiple groups that are owned by the same entity/entities

If any of the above conditions apply, tax documentation certifying that at least 80% common ownership must be submitted. Acceptable tax forms are (1) IRS Form 851 (Affiliations Schedule) with names of all entities or (2) Schedule K-1 (IRS Form 1065).

Section 9: Small Business Health Options Program (SHOP) Attestation

Have you completed the New York State SHOP eligible employer verification process and found that the Group named on page 1 of this application is SHOP eligible? ☐ Yes ☐ No

Section 10: Broker Information

☐ *I understand that the agency below may be entitled to a base and/or bonus compensation for our business. This broker information will remain in effect until we notify MVP Health Care otherwise.*

Broker Name	Agency Name		
Street Address	City	State	Zip Code
Billing Contact Email	Phone No. ( )	Fax No. ( )	

Continued on page 4

Company Name	*Tax ID No.*

Section 11: Private Exchange Information

Is this group to be enrolled through a private exchange (other than the NY State of Health™ Marketplace)? ☐ Yes ☐ No

If ***Yes***, please provide the name of the private exchange: _____

Section 12: MVP Representative Information

The information provided in this application is true to the best of my knowledge.

Name *(print)* Signature Date

Section 13: Authorization

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I have read and agree to the details outlined in *MVP's Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (825-5687).

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 five thousand dollars and the stated value of the claim for each violation.

I have read and agree to this authorization.

Signature Date

Name *(print)* Title