Excellus

Healthy NY Annual Re-Certification for Small Employers

This is your annual re-certification form for Healthy NY. In order to maintain your health insurance through the Healthy NY program, you must complete this form, showing that your business meets the program's guidelines. **Please note that there have been some changes to eligibility rules, as a result of changes in law.** If you do not meet the eligibility requirements for the program, ask your HMO/insurer about other options for health insurance coverage or contact the NY State of Health Small Business Marketplace at 1-855-355-5777.

Please read this form carefully as changes have been made. Please complete the requested information, and return it to the HMO or participating insurer your business is enrolled with. Please provide the most current information.

Note: Underwriting may require additional documents during review of the form, such as the most recently filed NYS-45 (or state equivalent).

Section 1: General Group Information

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

Company Name: _____ SIC Code: _____

HNY Group Number: _____ Tax Identification Number (EIN/TIN): _____

Street Address: _____

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

Telephone: _____ Fax No.: _____

Contact Person: _____ Title: _____ Telephone No.: _____

List Owners/Partners/Shareholders and Percentage of Ownership: *(Note: If there are more than four, please attach a separate listing.)*

Name: _____ _____% of Ownership Name: _____ _____% of Ownership

Name: _____ _____% of Ownership Name: _____ _____% of Ownership

Section 2:

Employer Size Requirements

In order to renew your 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 information on how to determine FTE employees the 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

*If your business has more than a total of 50 FTE employees, the business is no longer eligible for Healthy NY.

Total number of full-time employees and full-time equivalents at all locations, including subsidiaries and businesses under common control within the United States, in the prior calendar year: _____

Average number of employees and owners (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: _____

Total number of Dental eligible, enter total number employees (including active employees and owners, retirees and individuals enrolled in COBRA): _____

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Employer Premium Contribution

The business must continue to contribute at least 50% of the Healthy NY premium on behalf of the covered employees. Will the business continue to do so? ☐ Yes ☐ No

At least 30% of the employees offered Healthy NY coverage must earn $56,720 or less in annual wages.

☐ The business meets this requirement. ☐ The business does NOT meet this requirement.

If the business does not meet each of the requirements it is not eligible to continue to participate in the Healthy NY program.

Section 3: Contribution

If your organization offers Excellus BCBS dental, what is the monthly Employer Contribution to single tier dental? _____ %

If your organization offers Excellus BCBS vision, what is the monthly Employer Contribution to single tier vision? _____ %

Certification

By signing below, I certify that all statements contained in this form are true and accurate to the best of my knowledge. I further certify that I am an officer or owner of the business and duly authorized to execute this certification on behalf of the business.

Fraud Warning Statement:

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature: _____ Date: _____

Print Name of officer or owner: _____

Title: _____ Email: _____

Excellus BlueCross BlueShield will submit reports with respect to the benefit plan, in the time and manner required under Section 204 of the Transparency Provisions of the CAA and/or related regulations and/or other authoritative guidance issued under the CAA, on behalf of the group relating to pharmacy benefits and drug costs. In addition to the above, unless you notify Excellus BlueCross BlueShield otherwise, you are authorizing Excellus BlueCross BlueShield to complete and file with CMS a gag clause attestation on your behalf annually up until the date services are terminated as long as all of your benefits are entirely insured by Excellus BlueCross BlueShield. You agree to provide Excellus BlueCross BlueShield with any information that may be necessary in this respect.