MVP Health Plan, Inc.

Healthy NY Small Group Recertification

Instructions for Completing this Request

If the Employer is paying 100% of the employees' premiums, **all employees are required to enroll in coverage** under New York Sate Insurance Law §4235(c)(1)(A).

Submit all pages of this completed form and any required documents via email to your **MVP Account Representative** or **SBIU@mvphealthcare.com**, or by fax to **518-836-3279**.

Section 1: Group Information *(Please print)*

Group Name

Group No.

All Federal Tax ID No(s). (FEIN) Associated with Group

All Principal(s) of this Company *(include Owners, Officers, Directors, Partners, Legal Council, and Elected or Appointed Officials or Trustees)*

Name Title

Name Title

Name Title

Name Title

Section 2: Group Administration Details

For the purposes of the following questions, retirees and COBRA participants are not considered "employees" and should not be counted to determine group size. To convert the number of part-time employees to a full-time equivalent (FTE), 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.

What is the total number of part-time and full-time employees as of December 31 the prior year?

(Used to determine Coordination of Benefits for members 65 and older)

What is the total number of FTE employees as December 31 of the prior year?

(Used to determine if Small or Large Group)

*The full-time equivalent employee counting method in 26 U.S. Code § 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.

Section 3: Regulatory Information/Eligibility Requirements

Will your business continue to contribute at least 50% of the Healthy NY premium on behalf of covered employees? ☐ **Yes** ☐ **No**

Do at least 30% of the employees who will be offered coverage earn annual wages of $51,570 or less? ☐ **Yes** ☐ **No**

Section 4: Separate Entities with Multiple Tax ID Numbers

Only complete this Section if this circumstance applies to the Group recertifying. Group size for groups under common ownership is determined based upon the total Full-Time Equivalents (FTE) for all entities. To combine separate groups into one employer group for group insurance purposes, the commonly owned businesses or affiliates must qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Service section 414.

If any of the following conditions apply, tax documentation certifying that at least 80% common ownership may be required upon request, and MVP may, at its discretion, require the employer to submit documentation demonstrating common ownership under section 414. Acceptable tax forms are: (1) IRS Form 851 (Affiliations Schedule) with the names of all entities or (2) IRS Form 1065 (Schedule K-1).

Select all of the following conditions that apply to this Group.

☐ **Multiple Tax ID Numbers are listed in Section 1**

☐ **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**

Group Name *Group No.*

Section 5: Group Addresses and Contacts

Physical Street Address | City | State | Zip Code

County | Phone No. ( )

Mailing and Billing Street Address ☐ Same as Physical Address | City | State | Zip Code

County | Phone No. ( )

Health Benefits Administrator Main Contact | **Health Benefits Administrator** Business Email

Billing Contact Name | **Billing Contact** Email

Billing Contact Phone No. ( ) | **Broker/Agency** Name

Additional Business Locations

Include all business locations not listed above, including any located outside of New York State. If there are more than two additional locations, attached a separate page.

Street Address | City | State | Zip Code

County | Phone No. ( )

Street Address | City | State | Zip Code

County | Phone No. ( )

Section 6: Attestations

Small Business Health Options Program Attestation *(This attestation requires a response)*

The Small Business Health Options Program (SHOP) helps businesses provide health coverage to their employees. SHOP insurance is generally available to employers with 1–50 full-time equivalent employees (FTEs). For more information about SHOP, visit **cms.gov/cciio** and select *Health Insurance Marketplaces*, then *Small Business Health Options Program (SHOP)*.

Have you completed the New York State SHOP eligible employer verification process and found that the Group named in Section 1 of this form is SHOP eligible?

☐ **Yes. This Group has applied for and been approved for the SHOP** *(Include the SHOP letter when submitting this form)* ☐ **No**

MVP Vision Plan Attestation

If your group is enrolled in an MVP Vision plan and MVP Vision plan(s) are offered with non-voluntary rates, you attest that the employer contribution is 80% or more to the Vision plan premium.

Employer Initials

Group Name *Group No.*

Section 7: Authorization

For a group health plan to be considered a "group health plan" under the Employee Retirement Income Security Act (ERISA), there must be at least one common law employee enrolled as a contract holder. Pursuant to 29 CFR 2510.3-3(b), an "employee benefit plan" does not exist if no "employees" are covered by the plan. An "employee" does not include the owner(s) of a business or a spouse of the business owner. By signing this document, you attest that your group has made MVP Health Care coverage available to all common law employees and that at least one common law employee is currently enrolled with one of your group sponsored health plans for the term of the benefit year. Please note that waivers of coverage, including spousal waivers, cannot be used to determine group eligibility.	Employer Initials
MVP Health Care reserves the right to request your group's tax documents at any time throughout the year. Failure to produce requested documents could result in the termination of your group health insurance.	Employer Initials
I certify that, to the best of my knowledge and belief, and under penalty of perjury, the information listed on this form is true and complete, including that the persons proposed for coverage work at least 20 hours per week or are otherwise eligible for coverage.	Employer Initials
I understand that 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 such violation.	Employer Initials

Before signing below, please check that you have completed all Sections of this Application! This Application will be returned to you if any information is missing.

The parties agree that this authorization may be electronically signed. The parties agree that the electronic signature appearing on this Recertification form is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

Employer Signature *Date*

Employer Name (print) *Title*