UnitedHealthcare Oxford

Healthy NY Recertification and Plan Selection Form Small Group

Mail To: Healthy NY, Attn: Enrollment, 14 Central Park Drive, Hooksett, NH 03106

A. Group Information				
Group ID Number	Company Name			Phone Number
Address	City	State	Zip Code	
Contact Person	Title	Phone Number	Fax Number	

B. Contribution and Participation Requirements		
1. The Employer contributes at least 50% of the premium on behalf of the employees?	__Yes	__No
2. The business has fifty or fewer eligible employees?	__Yes	__No
3. Half of the employees have coverage via Healthy NY or another source.	__Yes	__No
4. 30% of the employees offered coverage earn $40,000* or less.	__Yes	__No
5. At least one participating employee earns $40,000* or less.	__Yes	__No

C. Plan Selection (Permitted at recertification of in the event of premium change)
Note: HMO Plans are only available to members who presently are enrolled on this plan.

_____	_____	_____	_____
HMO (no pharmacy)	HMO (with pharmacy)	High Deductible (no pharmacy)	High Deductible (with pharmacy)

High Deductible: The deductible is $1,200* for individuals and $2,400* for families (more than one person). Except for preventive care, you must pay for the cost of covered services until you meet the deductible. You can access preventive care before meeting the deductible and may have a co-payment for these services. Co-payments do not apply towards the deductible. Meant to be used with a health savings account. Contributions to the health savings account are tax-deductible, and money in the account can earn interest tax-free. You can contribute up to $3,100* for individual coverage and $6,250* for family coverage into the account. Visit www.HealthyNY.com to learn more about the high deductible option.

Coverage for Dependents through age 29: A Dependent who has attained the above limiting age can continue coverage until they reach age 30, subject to the eligibility requirements as outlined in the Certificate. Please choose one option below:

Dependent Age 29 Extension Benefit ___Yes ___ No

Submission of a completed Add/Term/Change form is required for dependent enrollment.

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D. Grandfathering and Non-Grandfathering
Please reference the attached Addendum for more information.*

Choose One: I am renewing with changes and/or have decreased my employer contributions by 5% or more _____Yes _____No

Choose One: I am not renewing with changes and/or have not decreased my employer contributions by 5% or more and would like to choose the:_____ Grandfathered Option _____ Non-Grandfathered Option

F. 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.

_____
Print Name and Title of officer or owner completing certification

_____
Signature Date

Any person who knowingly and with the intent to defraud an 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 an 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.

*These amounts may be increased in accordance with Federal Poverty Levels.