New York State Small Group Product Application

MVP Health Plan, Inc. | MVP Health Insurance Company | MVP Health Services Corp.

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

Company Name | SIC Code | Tax ID No. *(required)*

Street Address | Phone Number ( ) | Fax Number ( )

City | State | Zip Code | County

Group Contact Name | Group Contact Title | Phone Number ( )

Group Contact Email (this person will receive an MVP online account login) | Fax Number ( )

Additional Office Locations

Group Effective Date

Group Type

☐ Employer Group or Employer Trust ☐ Association or Chamber ☐ Taft Hartley Trust ☐ Labor Union

☐ Member of Controlled Group or Corporation ☐ Multiple Employer Trust

Section 2: Billing Contact Information *(please print)*

☐ Same as Group Contact above *(proceed to Section 3)*

Billing Contact Name | Billing Contact Title | Phone Number ( )

Street Address | City | State | Zip Code

Billing Contact Email | Fax Number ( )

Section 3: Other Group Contact Information *(if applicable)*

Contact Name | Contact Title

Contact Email | Phone Number ( )

Contact Name | Contact Title

Contact Email | Phone Number ( )

Section 4: Product Selection

☐ Platinum Plan No.

☐ Gold Plan No.

☐ Silver Plan No.

☐ Bronze Plan No.

☐ Medicare Gold

☐ Silver 4 with Embedded HRA

☐ Healthy NY

☐ Dependent through Age 29

☐ Unlimited Skilled Nursing

☐ MVP Dental PPO for Adults

☐ MVP Dental PPO for Families

☐ MVP Dental for Kids Plan*

☐ Delta Dental PPO Plan*

☐ Other

Desired Effective Date

* If you have purchased this Affordable Care Act (ACA) required benefit through another carrier, please complete Section 8 on page 2.

MVPform0072 (09/2016)

Company Name | *Tax ID No.*

Section 5: Group Administration

Total number of employees including full-time [1], part-time equivalent[2], seasonal equivalent[2], and 1099 employees _____

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

New hire eligibility policy: ☐ Date of hire ☐ First day of the month following date of hire

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

[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.

[2] 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.

Section 6: Other Group Coverage in Addition to MVP

1. Name of Other Carrier | Effective Date of Policy

Type of Coverage and Plan Design (metal level)

2. Name of Other Carrier | Effective Date of Policy

Type of Coverage and Plan Design (metal level)

Section 7: Enrollment Class/Subgroup

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

Does your group need a separate class/subgroup assigned for one of the following?

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

Section 8: Stand-Alone Dental Coverage

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NY State of Health™ Marketplace-certified, stand-alone dental plan offered outside the NY State of Health Marketplace? ☐ Yes ☐ No

If you answered *yes*, please provide the name of the company issuing the stand-alone dental coverage. _____

If you answered *no*, MVP will provide you with pediatric dental essential health benefit coverage.

Section 9: Certification

To the best of my knowledge, all the statements/responses in this application are true and complete. By signing this application, I certify that under penalty of perjury, that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business.

Insurance Fraud Statement

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 $5,000 and the stated value of the claim for each such violation.

Print Name | Title

Signature | Date

Company Name | *Tax ID No.*

Section 10: Broker Information *(please print)*

Broker Name | Firm Name

Street Address | City | State | Zip Code | Phone Number ( )

Email | Fax Number ( )

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 *(please print)*

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

Was a Broker involved in this sale? ☐ Yes MVP Broker No. _____ ☐ No

Print Name

Signature | Date

Questions? We're here to help. Call **1-800-TALK-MVP** (825-5687) Or visit **mvphealthcare.com**