United Healthcare Oxford

HEALTHY NY RECERTIFICATION AND SMALL GROUP PLAN SELECTION FORM

Oxford Health Insurance, Inc.

Mail To: Healthy NY, Attn: Enrollment, 4 Research Drive, Shelton, CT 06484

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 Requirement

If the business does not meet the requirements below, it is <u>not eligible</u> to continue to participate in the Healthy NY program.

1. The Employer contributes at least 50% of the premium on behalf of the employees?	☐ Yes	☐ No
2. The business has fifty or fewer full-time equivalent employees? (More than 50 total FTE employees (not eligible))	☐ Yes	☐ No
3. 30% of the employees offered coverage earn $51,570 or less.	☐ Yes	☐ No

C. Plan Selection

☐ EPO (with pharmacy)

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
- Domestic Partner Benefit: ☐ Yes ☐ No

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

Choose One:

- I am renewing with changes and/or have decreased my employer contributions by 5% or more
  ☐ Yes ☐ No

D. Certification

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 a 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.

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 completing certification

Signature

Date