

Healthy NY Application Instructions

Confidentiality Statement: Information provided on this application will remain confidential and will only be disclosed to the staff at health plans and state agencies operating this program.

Section A: Applicant information

In this section, we ask how to contact you.

Section B: Coverage options

1. Benefits

Healthy NY offers a standardized benefits package, with an optional prescription benefit. Choose if you want Healthy NY with a prescription drug benefit or without a prescription drug benefit.

Once you choose the benefit option, you will not be able to change your selection until your annual recertification or at the time of a premium rate change.

2. Deductible

All plans are subject to an annual deductible. The deductible amount is the amount you must spend out-of-pocket before services are covered. Preventive care can be accessed prior to meeting the deductible. For 2012, the deductible is \$1,200 for individuals and \$2,400 for families. The deductible amount may change annually and we encourage you to visit our website at www.healthyny.com for more information.

Section C: Employment information

To be eligible for Healthy NY, either you or your spouse must have worked at some point within the past 12 months. Please answer the employment questions.

Section D: Health insurance information

Healthy NY is for people who have been without comprehensive health insurance for 12 months or who have lost their health insurance due to certain specific events. Please answer the questions in Section D regarding prior health insurance coverage. Canceling other insurance due to cost does not entitle you to coverage.

Section E: Household income

In order to qualify for Healthy NY, your household income must fall within the limits set by law. Please list your current gross (before taxes) monthly income and the current gross monthly income of your spouse (if residing in your household). No one else's income is counted.

2012 Healthy NY Monthly Income Guidelines

PERSONS IN FAMILY	GROSS INCOME
1	Up to \$2,327
2	Up to \$3,152
3	Up to \$3,977
4	Up to \$4,802
5	Up to \$5,627
6	Up to \$6,452
Each Additional Person	Add \$825

Pregnant women count as two people.
Income levels are updated annually.

Section F: Household Members

Please complete the chart in Section F. Include information for yourself, your spouse and your children. If you are a sole proprietor, you may include information about your domestic partner, if applicable. Spouses and domestic partners must reside in your household. Do not count other people residing in your household, such as parents, roommates, etc.

Section G: Documentation

Documentation of NYS residence, employment status, and household income must be included with your application. Submit documentation of current income such as your most recent pay stubs. You must include documentation that shows your income for the last month. If this information is not available or not representative of your normal income, submit your tax return or business documentation and provide an explanation of the documentation.

Section H: Certification

Please carefully review and complete the certification set forth in Section H.

Submitting Your Application Detach and send your completed applications directly to the HMO or participating insurer that you choose. For a list of HMOs and participating insurers and their addresses and rates, go to www.HealthyNY.com and select the link "HMOs and Rates by County." Applicants whose completed applications are received by the 20th of the month may be enrolled by the 1st of the following month. For faster processing, include a check for the first month's premium, made payable to the HMO or participating insurer. If you have questions, or to check the status of your application, please call your chosen HMO or participating insurer directly.

Section A: Applicant information

Mr. Mrs. Ms. Miss Male Female

Name: First _____ Middle Initial _____ Last _____

Telephone: Home (_____) _____ Work (_____) _____

Street address of person applying for coverage:

Street _____

City _____ State _____ ZIP _____ County _____

Mailing address if different then street address

Street _____

City _____ State _____ ZIP _____ County _____

Section B: Coverage Options

Healthy NY is available with or without prescription drug coverage. Premiums are higher for coverage with a drug benefit. All Healthy NY coverage options have a deductible of \$1,200 for individual coverage (\$2,400 for family coverage) for 2012. Preventive services are covered before meeting the deductible.

Please select your coverage option:

Healthy NY
with drug coverage

Healthy NY
without drug coverage

Section C: Employment Information

1. Please indicate whether you are applying as an individual or as a sole proprietor. A sole proprietor is someone who is the sole owner and only employee of a business, regardless of the business's format.

Individual

Sole proprietor – You will be asked to submit proof of self-employment

2. You can qualify for Healthy NY if either you or your spouse worked during the past 12 months. Please answer the following questions about employment:

Who is currently employed? You Spouse Neither

Who has worked in the past 12 months? You Spouse Neither

If both questions above are answered "Neither," then you will not qualify for Healthy NY.

Section D: Health insurance information

Healthy NY is available to individuals who have not had comprehensive (medical **and** hospital) health insurance coverage in place during the past 12 months or have lost their insurance due to certain reasons. Please answer the following questions:

1. Have you had health insurance coverage that included both medical and hospital benefits during the past 12 months? Note: Answer "Public Program" if your coverage was through Medicaid, Child Health Plus, Family Health Plus, Healthy NY, or another public health program.

- Yes
 No
 Public Program
 Name of Public Program _____

2. If you have had comprehensive health insurance coverage during the past 12 months, please indicate the reason(s) for termination. Please check all that apply.

- Losing employment
- Changing to a new employer, leaving the workforce, or retiring
- Changing residence
- Death of a family member
- Legal separation, divorce, or annulment
- Reaching the maximum age under your policy
- Losing eligibility for group health insurance coverage
- Discontinuing a group health insurance plan
- Terminating or canceling COBRA/continuation coverage

3. Date coverage terminated or will terminate due to reason noted in 2.

_____ / _____ / _____

Section E: Household income

Income limitations are set by law. Please list your current monthly **gross** income and the current monthly **gross** income of your spouse (if residing in your household). Gross income is before taxes. Income includes salary, wages, commissions, royalties, alimony received, self-employment income, rental income, interest and dividends from investments and accounts, public or private retirement or pension benefits, Social Security Income, and unemployment and workers' compensation benefits. Income **does not** include public assistance, Supplemental Security Income (SSI), child support or foster care payments made to you, profits from the sale of your residence, and account withdrawals or capital gains.

Applicant's current monthly gross income \$ _____
 Spouse's current monthly gross income \$ _____
TOTAL \$ _____

Note: Sole proprietors may deduct their documented monthly business expenses in calculating monthly income.

Section F: Household Members

The household income limitation depends on the number of household members that you have. Household members include yourself, your spouse (if residing in the household), and dependent children. For each person listed, please indicate whether that person is applying for coverage. Sole proprietors may include a domestic partner, if they want coverage for the domestic partner under the policy. Fill in the name of the primary care physician chosen by each person to be covered, if known.

Applicant's Name (First, MI, Last)	DOB	Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number
	Name of Primary Care Physician (If Known): Physician		
Spouse's or Domestic Partner's Name (First, MI, Last)	DOB	Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	DOB	Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	DOB	Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	DOB	Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number
	Name of Primary Care Physician (If Known):		
Child's Name (First, MI, Last)	DOB	Applying for Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number
	Name of Primary Care Physician (If Known):		

Pregnant women count as two people for determining household size. Are any of the household members listed above pregnant?

No Yes (Name _____)

Are any of the household members eligible for Medicare? Medicare is federal health insurance for people of all incomes. It is usually for people age 65 and older, and people who are disabled.

No Yes (Name _____)

Section G: Documentation

You must attach documentation of NYS residence, employment within the past 12 months for you or your spouse, and your household income. Documentation should match your statements in earlier sections of the application. You must include documentation that shows your entire current monthly income, such as pay stubs for an entire month. Note that one document can fulfill more than one category. Please check the boxes below that show which types of documentation you are submitting.

NYS Residence (should match Section A)	Employment (should match Section C)	Household Income (should match Section E)
<input type="checkbox"/> NYS driver license <input type="checkbox"/> Utility bill (gas, electric, cable, etc.) or postmarked mail with address <input type="checkbox"/> Letter/lease/rent receipt from landlord <input type="checkbox"/> Property tax records or mortgage statement <input type="checkbox"/> Other (explain):	<input type="checkbox"/> Pay stubs <input type="checkbox"/> Letter from employer <input type="checkbox"/> Documentation sufficient to demonstrate self-employment <input type="checkbox"/> Other (explain): <hr/> <hr/>	<input type="checkbox"/> Pay stubs <input type="checkbox"/> Award letters/benefit checks <input type="checkbox"/> Business records <input type="checkbox"/> Letter from employer <input type="checkbox"/> Other (explain): <hr/> <hr/> <hr/>

Section H: Certification

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true to the best of my knowledge. I further certify that I am ineligible for health insurance provided by my employer and all individuals to be covered are ineligible for Medicare.

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 five thousand dollars and the stated value of the claim for each such violation.

 Applicant's Signature Date

If a broker assisted you with completing this application, please include:

 Broker's Name License # Company

 Address Phone E-mail

Important Information about Pre-existing Conditions

A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months. Your Healthy NY policy will exclude coverage for that condition for up to 12 months. Pregnancy is a pre-existing condition in individual contracts, and coverage may be excluded for up to 10 months. Pregnancy is not a pre-existing condition for sole proprietors. This period may be reduced or eliminated if you are transferring from other health insurance coverage, which terminated no more than 63 days prior to the date that you submit your Healthy NY application. There are no pre-existing condition exclusions for anyone under 19. Please review your Healthy NY health insurance policy or contact your HMO for a full explanation of what is considered a pre-existing condition and how this restriction may affect you.

The 12-month exclusion period mentioned above is shorter if you have been determined to be eligible under the Federal Trade Adjustment Act of 2002. Please notify your HMO.

Detach and send your completed application directly to the HMO or participating insurer that you choose. For a list of HMOs and participating insurers and their addresses and rates, go to www.HealthyNY.com and select the link "HMOs and Rates by County."