UnitedHealthcare®
Oxford

Healthy NY Application for Individuals and Sole Proprietors

INSTRUCTIONS

Please note that small group employers wishing to purchase Healthy NY must complete a different application.

Please see the Healthy NY Consumer Guide or log on to **www.healthyny.com** for a full description of the Healthy NY eligibility requirements. You may obtain a consumer guide by calling 1-866-HealthyNY (1-866-432-5849).

Confidentiality Statement. All of the information you provide on this application will remain confidential. The only people who will see this information are the health plans and state agencies who need to determine if you are eligible to purchase Healthy NY.

COVERAGE OPTIONS

Benefit Options

Healthy NY offers a standardized benefit package with an optional limited prescription benefit. Choose if you want Healthy NY with or without a prescription drug benefit. Once you choose whether or not you want prescription drug coverage, you will not be able to change your selection until your annual recertification or if your premium rate changes.

Deductible

If you are a newly enrolled Healthy NY Member, you will be enrolled in a High Deductible Health Plan. A High Deductible Health Plan (HDHP) is designed to be used with a health savings account (HSA). This is a savings account used to pay for qualified medical expenses. Contributions are tax-deductible, and money in the account can earn interest tax-free. You can contribute up to $3,250* for individual coverage and $6,450* for family coverage into the account in 2013.

The deductible is $1,250* for individuals and $2,500* for families (more than one person). Copayments do not apply towards the deductible.

*These amounts may be increased in accordance with Federal Government annual increases.

SECTION A. APPLICANT INFORMATION

In this section, we ask how to contact you. Please list your home address and your mailing address, if different. **Note that your response must be received by or before the 20th of the month for coverage to be effective on the first of the following month.**

SECTION B. EMPLOYMENT INFORMATION

You can qualify for Healthy NY if you worked during the past 12 months. If you have not worked in the past 12 months, you can still qualify if your spouse was employed during the past 12 months. Please answer the questions in Section B about employment.

SECTION C. INSURANCE INFORMATION

Healthy NY is available to those who have been without health insurance for 12 months and those who have lost their health insurance due to qualifying reasons. Some qualifying reasons include loss of health insurance coverage due to job loss, divorce or separation, death of a spouse, and change in residence. Please fully complete the questions in Section C regarding prior health insurance coverage. Please note that cancelling other insurance due to cost is not a qualifying reason.

SECTION D. HOUSEHOLD INCOME

In order to qualify for Healthy NY, your household income must fall within the limits established for the program. Please list your current gross monthly income and the current gross monthly income of your spouse (if residing in your household) in the space provided in Section D. No one else's income is counted.

Please include wages, salary, self-employment income, interest and dividends, social security income, retirement income, alimony, unemployment benefits and workers' compensation. Please do not include public assistance, supplemental security income (SSI), foster care payments or child support payments you receive.

INSTRUCTIONS (CONT)

SECTION E. HOUSEHOLD MEMBERS

Please fully complete the chart in Section E. Include information regarding yourself, your spouse, your domestic partner (if you are a sole proprietor) and your children. Spouses and domestic partners must reside in your household. Please include information on each of these individuals even if you do not wish to purchase Healthy NY coverage for them.

The Healthy NY income limitations vary for households of different sizes. Refer to the chart below to determine if you meet the Healthy NY household income requirements. For those applying for coverage, please provide the name of the primary care physician chosen, if known.

Family Size	Monthly Household Income
1	Up to $2,394*
2	Up to $3,232*
3	Up to $4,070*
4	Up to $4,908*
5	Up to $5,746*
6	Up to $6,584*
Each Additional:	Add $838*

*These amounts may be increased in accordance with NY Department annual increases.

Amounts effective 1/1/13.

Pregnant women count as two people.

SECTION F. DOCUMENTATION

Please review Section F. Documentation of New York State residence, employment status and household income must be included with your application.

SECTION G. HEALTHY NY PLAN ELECTION

Please select whether you want Healthy NY with prescription drug coverage or without prescription drug coverage. Also, please select option for Dependent Coverage Extension.

SECTION H. CERTIFICATION

Please review and complete the certification set forth in Section H. If you are eligible for the Federal Tax Adjustment Act of 2002, a certificate of eligibility must be included with your application.

SUBMITTING YOUR APPLICATION

Your last step in applying for Healthy NY is to submit your application directly to Oxford.

To submit this application, please mail it directly to: **Healthy NY Department, 14 Central Park Drive, Hooksett, NH 03106** Additional paperwork will be requested if necessary to complete the enrollment process.

DON'T FORGET!

- **Sign your application!**
- **Enclose proof of applicant's address!**
- **Enclose first month's premium!**

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Healthy NY Application for Individuals and Sole Proprietors - HMO

Oxford Health Plans (NY), Inc.

Mailing Address: Healthy NY Department, 14 Central Park Drive, Hooksett, NH 03106

Please see the Healthy NY Consumer Guide or log on to **www.healthyny.com** for a full description of the Healthy NY eligibility requirements. You may obtain a consumer guide by calling 1-866-HealthyNY (1-866-432-5849).

SECTION A. APPLICANT INFORMATION

Name First	Middle Initial	Last	
Telephone Number Home ( )	Work ( )		
Address of Person Applying for Coverage Street			
City	State	Zip	County
Mailing Address (if different than above) Street			
City	State	Zip	County
Requested Effective Date / 01 / Month / Day / Year			

SECTION B. 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.

   ❑ Individual
   ❑ Sole Proprietor

Note to sole proprietors only: Sole proprietors may offer Healthy NY coverage to their domestic partner. Will your business be offering Healthy NY coverage to a domestic partner?

❑ Yes ❑ No

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

Currently employed:	❑ You	❑ Your spouse	❑ Neither
Worked in the past year:	❑ You	❑ Your spouse	❑ Neither

If both questions are answered “Neither”, you will not qualify for Healthy NY.

SECTION C. HEALTH INSURANCE INFORMATION

Healthy NY is available to individuals who have not had comprehensive health insurance coverage in place during the past 12 months OR have lost their insurance due to certain reasons. Please answer the following questions to assist us in determining your eligibility.

1. Have you had health insurance coverage which included both medical and hospital benefits during the past twelve months? (Note: Answer "No" if your coverage was through Medicaid, Child Health Plus, Family Health Plus, Healthy NY or another public program or if you had COBRA coverage.)

   ❑ Yes
   ❑ No

2. If you have had comprehensive health insurance coverage during the past twelve months, did it terminate for one of the following reasons? (Please check all that apply.)

   ❑ Loss of employment
   ❑ Change to a new employer
   ❑ Change of residence
   ❑ Death of a family member
   ❑ Legal separation, divorce or annulment
   ❑ Reached the maximum age under your policy
   ❑ Loss of eligibility for group health insurance coverage
   ❑ Discontinuation of a group health insurance plan
   ❑ Termination or cancellation of COBRA/continuation coverage

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

4. What kind of coverage do you want?

   ❑ Single
   ❑ Family
   ❑ Husband and Wife
   ❑ Parent and Child(ren)

5. Integration with Medicare Benefits: Health Benefits covered by Medicare Part A, Part B and Part D are carved out for members age 65 or over.

SECTION D. HOUSEHOLD INCOME

Please list your current monthly gross income and the current monthly gross income of your spouse (if residing in your household). Please include wages, salary, interest and dividends, self-employment income, social security income, retirement income, alimony, unemployment benefits and workers' compensation. Please **do not** include public assistance, supplemental security income (SSI), foster care payments or child support received.

Applicant's Current Monthly Gross Income	$
Spouse's Current Monthly Gross Income	$
Total	$

(Please Note: Sole proprietors should deduct their monthly business expenses in calculating their monthly income.)

SECTION E. HOUSEHOLD MEMBERS

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

Applicant's Name	Male/ Female	Date of Birth	Applying for Coverage?	Social Security #	Eligible for Medicare?	PCP Oxford ID#/Name
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Spouse or Domestic Partner						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Child's Name						
(First, MI, Last)	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	

Pregnant women count as two people for determining household size.
Are any of the household members listed above pregnant? ❑ No ❑ Yes (Who? _____)

SECTION F. DOCUMENTATION

IMPORTANT! You **must** attach documentation of **New York State residence**, your **employment status** and your **household income**. Please include at least one from each category. If this information is not available or not representative of your typical income, please submit your tax return or business documentation and explanation of the documents. The following are examples of acceptable documentation:

New York State Residence	Employment Status	Income
❑ New York State driver's license	❑ Pay stubs	❑ Letter from employer
❑ Utility bill (gas, electric, cable) or postmarked mail with address	❑ Letter from employer	❑ Pay stubs
❑ Letter/lease/rent receipt with home address from landlord	❑ Documentation sufficient to demonstrate self-employment	❑ Business Records
❑ Property Tax Records or Mortgage Statement	❑ Other (please explain): _____	❑ Award letters/benefit checks
❑ Other (please explain):		❑ Other (please explain): _____

Note: Individuals who are transferring from New York's Voucher Insurance Program or the New York State Health Insurance Partnership Program should attach proof of participation in these programs in lieu of the documentation listed above.

SECTION G. HEALTHY NY PLAN ELECTION

Plan Elections:

Please elect one of the four (4) available Healthy NY plans:

A. Healthy NY with prescription drug coverage** ❑ Yes
B. Healthy NY without prescription drug coverage** ❑ Yes
C. Healthy NY HDHP prescription drug coverage ❑ Yes
D. Healthy NY HDHP without prescription drug coverage ❑ Yes

** This option is only available for Oxford Health Plan Healthy NY Members enrolled prior to January 1, 2012 with no break in coverage.

Additional Benefit Options:

❑ Dependent Coverage Extension through age 29
❑ None

Important: Your election may only be changed upon annual renewal/recertification or upon a change in rates. Your renewal or recertification occurs annually when you are required to complete the Recertification of Coverage documentation.

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.

Important!

Please Note: A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received with the last six months. Your Healthy NY policy will exclude coverage for that condition for **up to 12 months**. However, 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. Note: This provision does not include children under the age of 19.

As of 6/1/03, individuals who are eligible for a federal tax credit for payment of health insurance premiums, pursuant to the federal Tax Adjustment Act of 2002, and have three months of creditable coverage prior to the enrollment date with no break of coverage greater than 63 days shall not be subject to a pre-existing condition waiting period. Please notify Oxford by providing a certificate of eligibility with your application.

Please review your Healthy NY health insurance policy or contact **Oxford** for a full explanation of exactly what constitutes a pre-existing condition and how this restriction will affect you.

This application should be forwarded directly to Oxford. To submit this application, please mail it to:

Healthy NY Department
14 Central Park Drive
Hooksett, NH 03106

Signature _____ Date _____