MVP Health Plan, Inc. and MVP Health Services Corp.

New York State Small Group Recertification

Instructions for Completing this Request

Complete one form for each unique group. If the Employer is paying 100% of the employees' premiums, **all employees are required to enroll in coverage** under New York Sate Insurance Law §4235(c)(1)(A).

Submit all pages of this completed form and any required documents via email to your **MVP Account Representative** or **SBIU@mvphealthcare.com**, or by fax to **518-836-3279**.

Section 1: Group Information *(Please print)*

Group Name

Group No.

All Federal Tax ID No(s). (FEIN) Associated with Group

All Principal(s) of this Company *(include Owners, Officers, Directors, Partners, Legal Council, and Elected or Appointed Officials or Trustees)*

Name | Title

Name | Title

Name | Title

Name | Title

Section 2: Group Administration Details

Solely for purposes of determining whether an employer is a large or small employer, the employer is required to calculate the number of Full-Time Equivalents (FTE) it employed **during the most recent rolling 12 months**, and count each such FTE as one full-time employee. Refer to the employee definitions below.

Common Law Employees are eligible for health Insurance coverage. Common law employees are defined as anyone who performs services for an employer as long as the employer has financial and/or behavioral control for these employees. Leased employees, 1099 employees, and union employees are considered employees under this definition and should be included in the group size count.

Retirees are not "employees" and are not counted in group size.

Part-Time Employees are those who work less than 30 hours per week and are counted using the FTE counting method. To convert the number of part-time employees to an FTE number, the average monthly 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.

COBRA participants are not included in the FTE calculation for determining group size.

To assist you in calculating your group's part-time FTEs, visit **irs.gov/affordable-care-act** and select *Employers*, then *Determining if an Employer is an Applicable Large Employer.*

What is the total number of part-time and full-time employees during the most recent rolling 12 months?

(Used to determine Coordination of Benefits for members 65 and older)

What is the total number of FTE employees during the most recent rolling 12 months?

(Used to determine if Small or Large Group)

Are more than 50% of your enrolled employees within the MVP service area? ☐ Yes ☐ No

Contact your broker or MVP Account Representative if you are unsure which states and counties are covered within the MVP regional service area.

*The full-time equivalent employee counting method in 26 U.S. Code § 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.

Group Name *Group No.*

Section 3: Separate Entities with Multiple Tax ID Numbers

Only complete this Section if this circumstance applies to the Group recertifying. Group size for groups under common ownership is determined based upon the total Full-Time Equivalents (FTE) for all entities. To combine separate groups into one employer group for group insurance purposes, the commonly owned businesses or affiliates must qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Service section 414.

If any of the following conditions apply, tax documentation certifying that at least 80% common ownership may be required upon request.

If any of the following conditions apply, MVP may, at its discretion, require the employer to submit documentation demonstrating common ownership under section 414.

Acceptable tax forms are: (1) IRS Form 851 (Affiliations Schedule) with the names of all entities or (2) IRS Form 1065 (Schedule K-1).

Select all of the following conditions that apply to this Group.

- ☐ **Multiple Tax ID Numbers are listed in Section 1**
- ☐ **This/These Groups are owned by another entity**
- ☐ **This Group owns another entity**
- ☐ **This Group is one of multiple groups that are owned by the same entity/entities**

Section 4: Group Addresses and Contacts

Physical Street Address | City | State | Zip Code

County | Phone No. ( )

Mailing and Billing Street Address ☐ Same as Physical Address | City | State | Zip Code

County | Phone No. ( )

Health Benefits Administrator Main Contact | **Health Benefits Administrator** Business Email

Billing Contact Name | **Billing Contact** Email

Billing Contact Phone No. ( ) | **Broker/Agency** Name

Additional Business Locations

Include all business locations not listed above, including any located outside of New York State. If there are more than two additional locations, attach a separate page.

Street Address | City | State | Zip Code

County | Phone No. ( )

Street Address | City | State | Zip Code

County | Phone No. ( )

Group Name *Group No.*

Section 5: Attestations *(*Response Required)*

Small Business Health Options Program Attestation

The Small Business Health Options Program (SHOP) helps businesses provide health coverage to their employees. SHOP insurance is generally available to employers w ith 1–50 full-time equivalent employees (FTEs). For more information about SHOP, visit **cms.gov** and select *Marketplace & Private Insurance*, then *Agents & Brokers*, then *SHOP Resouces*.

Have you completed the New York State SHOP eligible employer verification process and found that the Group named in Section 1 of this form is SHOP eligible?

☐ **Yes. This Group has applied for and been approved for the SHOP*** *(Include the SHOP letter when submitting this form)*

☐ **No**

MVP Vision Plan Attestation

If your group is enrolled in an MVP Vision plan and MVP Vision plan(s) are offered with non-voluntary rates, you attest that the employer contribution is 80% or more to the Vision plan premium.

Employer Initials

☐ **Our Group would like to add an MVP Vision plan.**

Section 6: Authorization

For a group health plan to be considered a "group health plan" under the Employee Retirement Income Security Act (ERISA), there must be at least one common law employee enrolled as a contract holder. Pursuant to 29 CFR 2510.3-3(b), an "employee benefit plan" does not exist if no "employees" are covered by the plan. An "employee" does not include the owner(s) of a business or a spouse of the business owner.

By signing this document, you attest that your group has made MVP Health Care coverage available to all common law employees and that at least one common law employee is currently enrolled with one of your group sponsored health plans for the term of the benefit year. Please note that waivers of coverage, including spousal waivers, cannot be used to determine group eligibility.

Employer Initials

MVP Health Care reserves the right to request your group's tax documents at any time throughout the year. Failure to produce requested documents could result in the termination of your group health insurance.

Employer Initials

I certify that, to the best of my knowledge and belief, and under penalty of perjury, the information listed on this form is true and complete, including that the persons proposed for coverage work at least 20 hours per week or are otherwise eligible for coverage.

Employer Initials

I understand that any person who knowingly and with 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.

Employer Initials

Before signing below, please check that you have completed all Sections of this Application! This Application will be returned to you if any information is missing.

The parties agree that this authorization may be electronically signed. The parties agree that the electronic signature appearing on this Recertification form is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

Employer Signature *Date*

Employer Name (print) *Title*