OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

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.

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. If you have not worked in the past, you can still qualify if your spouse was employed during the past. 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.

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.

SECTION E. HOUSEHOLD MEMBERS

Please fully complete the chart in Section E. Include information regarding yourself, your spouse (if residing in your household) and your children. 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	Annual Household Income	Monthly Household Income
1	Up to $23,800	Up to $1,984
2	Up to $31,950	Up to $2,663
3	Up to $40,100	Up to $3,342
4	Up to $48,250	Up to $4,021
5	Up to $56,400	Up to $4,700
Each extra person	Add $8,150	Add $680

Amounts effective 1/1/05. 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 (annual limit of $3,000) or without prescription drug coverage.

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 Health Plans (NY), Inc.

To submit this application directly to Oxford please mail it to: **Oxford Health Plans (NY), Inc., Attn: Healthy New York Department, 14 Central Park Drive, Hookset, 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!**

OXFORD HEALTH PLANS®
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Healthy NY HMO Application for Individuals and Sole Proprietors

Oxford Health Plans (NY), Inc.

Mailing Address: Oxford Health Plans, Attn: Healthy New York 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. 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 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. Were you enrolled during the past 90 days?

   ❑ Yes*
   ❑ No

***If you checked "Yes," and you are not eligible for Medicare, then you are automatically eligible for Healthy NY. Please attach proof of your enrollment in one of these public programs.**

4. What kind of coverage do you want?

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

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. Fill in the name of the primary care physician (PCP) chosen by each person to be covered, if known.

Applicant's Name (First, MI, Last)	Male/ Female	Date of Birth	Applying for Coverage?	Social Security #	Eligible for Medicare?	PCP Oxford ID#/Name
	❑ M ❑ F		❑ Yes ❑ No		❑ Yes ❑ No	
Spouse'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	
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. The following are examples of acceptable documentation:

New York State Residence	Employment Status	Income
❑ New York State driver's license	❑ Pay stubs	❑ Pay stubs
❑ Utility bill (gas, electric, cable)	❑ W-2 forms	❑ W-2 forms or tax returns
❑ Postmarked mail with address	❑ Letter from employer	❑ Letter from employer
❑ 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.

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SECTION G. HEALTHY NY PLAN ELECTION

Please elect one of the two available Healthy NY plans:

A. Healthy NY with prescription drug coverage **(maximum $3,000 per person annually)** ❑ Yes

B. Healthy NY without prescription drug coverage ❑ Yes

Important: Your election may only be changed upon annual renewal/recertification. 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: If you are applying for coverage and you have a pre-existing condition, your Healthy NY policy will exclude coverage for that condition for up to 12 months. However, this 12 month 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 you submit your Healthy NY application.

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 Health Plans (NY), Inc. To submit this application directly to Oxford please mail it to:

Oxford Health Plans (NY), Inc.
Attn: Healthy New York Department
14 Central Park Drive
Hooksett, NH 03106

Signature ______________________________ Date ______________

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