

# EMPLOYER ATTESTATION

## ARRA STATE CONTINUATION/EMPLOYEE SUBSIDY



**Please submit completed form to:**  
**HIP Health Plan of New York**  
**P.O. Box 2806**  
**New York, NY 10116-2806**

### Employer Information

Employer Group Name:		
Group ID Number:		
Contact Name:		
Employer Group Address:	City/State/Zip Code:	Contact Phone:
Did your group have 20 or more employees on more than 50% of your typical business days in the previous calendar year? * <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you offer more than one health plan option to your employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Will you allow Assistance Eligible Individuals (AEIs) to change coverage to a different coverage option than the plan in which they were enrolled when they lost eligibility?* <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list the type of coverage, the carrier, and the current premium rate for each coverage offered:		
Type of Coverage:	Carrier:	Premiums:

### Participant Information

Applicant Name:	Employee Name:
Subscriber ID:	Member ID (if different from subscriber ID):
Address:	City/State/Zip Code:
Did the applicant lose eligibility under the group health plan due to the employee's involuntarily termination of employment, as defined by the US Department of Labor*, between September 1, 2008 and December 31, 2009? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please Specify Date of Involuntary Termination:	
Please Specify Date of Termination of Coverage:	
Was the applicant covered under the group health plan on the day before the event that resulted in the loss of eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the applicant a non-resident alien? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the applicant enrolled in any other employer group coverage to your knowledge? <input type="checkbox"/> Yes <input type="checkbox"/> No	

If the applicant is not the employee, is the applicant one of the following: 1) the subscriber's opposite sex spouse; 2) the employee's natural dependent child; 3) a dependent child for whom the employee has legal guardianship; or 4) a child placed for adoption with the employee during a period of continuation of coverage?  Yes  No

If no, please describe the applicant's relationship to the subscriber:

Does the group pay (or will the group pay) for all or part of the premiums for continuation of coverage for the above referenced former employee and/or his/her dependents?  Yes  No

If yes, please specify the following:

Amount Contributed to Premiums:

Length of Time Contribution Will Continue:

If your group is changing or recently changed to HIP Health Plan of New York coverage from another insurer and the applicant is/was a continuation beneficiary at the time of the coverage change, please answer the questions below:

Is/was the applicant receiving an ARRA premium reduction from the other insurer?  Yes  No

Specify the month, day and year the applicant's reduced premium was first billed by the other insurer: \_\_\_/\_\_\_/\_\_\_

**Please refer to the information below for further explanation of these items.**

**Please be certain to sign and date the formal attestation below as required.**

I, [\_\_\_\_\_print name] hereby attest, under penalty of perjury, that I possess the information and authority to make the statements on this Employer Attestation Form on behalf of the employer and that all information contained in this form is true and accurate to the best of my knowledge. I understand that HIP Health Plan of New York will rely on my statements above in order to determine the eligibility of the noted individuals for a federal subsidy pursuant to the American Recovery and Reinvestment Act of 2009 ("ARRA") for continuation of coverage under New York State law and that the Employer and/or I may be liable to HIP Health Plan of New York for any and all damages, penalties and other expenses incurred by HIP Health Plan of New York in the event that the information above is determined at any time to be false and the individuals above are found to not be "Assistance Eligible Individuals" pursuant to the ARRA.

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 purposes 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.

Signature / Print Name

Title and Employer

Date

To assist in your completion of the attached form, please refer to the explanations below:

**NUMBER OF EMPLOYEES:** Both full and part-time employees must be counted. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.

**CHANGING COVERAGE OPTIONS:** Note that the different coverage offered must meet the following conditions: it must cost the same or less than the coverage the individual(s) had at the time of the qualifying event; you must offer the different coverage to active employees; and the different coverage cannot be limited to only dental, vision, and/or counseling, a flexible spending arrangement (FSA), including a health reimbursement arrangement that qualifies as an FSA, or an on-site medical clinic.

**INVOLUNTARY TERMINATION:** A severance from employment due to the independent exercise of unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services. For more information about what circumstances constitute involuntary end of employment, please refer to the United States Internal Revenue Department website at <http://www.irs.gov/newsroom/article/0,,id=204505,00.html> and/or the United States Department of Labor website <http://www.dol.gov/ebsa/cobra.html> regarding "involuntary termination."