

# Individuals and Sole Proprietors

## INSTRUCTIONS FOR HEALTHY NEW YORK APPLICATION

Please read these instructions when completing the Healthy New York Individual and Sole Proprietor Application. Upon completing the application, return it to: HIP Health Plan of New York, Healthy New York Program, P.O. Box 2793, New York, NY 10116-2793

### SECTION A. APPLICANT INFORMATION

**Name** – This section should be completed by the individual applying for insurance. Fill in your first name, middle initial and last name, and provide a phone number where you can be reached if additional information is needed to process your application.

**Street Address** – Fill in the address where you live. If your billing address is different (such as a post office box), please also provide your billing address.

**Marital Status** – Please indicate your marital status.

**Emergency Contact** – List a contact in case of emergency.

**Primary Care Physician** – Please select a primary care physician from HIP's provider network.

**Type of Application** – Please indicate if you are applying as an individual or as a sole proprietor. A sole proprietor is defined as someone who is the sole owner of a business and is also the only employee of the business.

**Benefit Package** – Please indicate if you are applying for the benefit package without prescription drug coverage, the benefit package with prescription drug coverage (maximum of \$3,000 per person annually), the benefit package with High Deductible Health Plan coverage (HDHP) without prescription drug coverage, or the benefit package with High Deductible Health Plan coverage (HDHP) with prescription drug coverage. The premiums are different for each benefit package.

**Deductible (HDHP)** – Choose if you want a yearly deductible or a plan with no deductible. Once you choose whether or not you would like a deductible, you will not be able to change your selection until annual recertification.

The deductible option has a lower premium. The deductible is \$1,200 for individuals and \$2,400 for families (more than one person). Except for preventive care, you must pay for the cost of covered services until you meet the deductible. You can access preventive care before meeting the deductible and will have a co-payment for these services. Co-payments do not apply towards the deductible.

The deductible plan option qualifies as a High Deductible Health Plan (HDHP) that 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 \$3,050 for individual coverage and \$6,150 for family coverage into the account in 2010.



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**You should carefully consider all options before making a decision.** Visit [www.HealthyNY.com](http://www.HealthyNY.com) for more information.

## SECTION B1. HOUSEHOLD MEMBERS

This section should be completed for the applicant, the applicant's legal spouse if residing in the household, the applicant's domestic partner if a sole proprietor and if residing in the household, and any dependent children. Provide the full name, social security number, relationship, sex, selection of a primary care physician for each person who will be covered, date of birth, and whether the person is eligible for Medicare. Indicate health insurance coverage information in the past 12 months. Also, indicate if each person is applying for coverage.

Check "Yes" if any household members listed are pregnant and list how many in the space provided.

**Who may be covered.** The following people are eligible to be covered under your contract:

- The applicant.
- The applicant's legal spouse (or domestic partner if you are a Sole Proprietor), if residing in the household.
- Your married or unmarried children under the age of 26, regardless of student status.
- Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness or developmental disability, or because of physical handicap.
- A legally adopted child.
- A stepchild who is dependent upon you for support.
- A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final.

## SECTION B2. HOUSEHOLD INCOME

This section will be used to determine household income. In order to qualify for Healthy New York coverage, you must meet certain household income limits. The amount of allowable income varies depending upon the number of people you included in Section B1.

The monthly gross income of the applicant and legal spouse (or domestic partner if you are a Sole Proprietor) if residing in the household listed in Section B1 must be listed in Section B2. If the person has no income, write "none" in the space provided. Sources of income to be considered are listed below:

### **Income to be included:**

- Wages or Salary (including commissions, overtime compensation, fees or tips)
- Self-employment Income
- Social Security Benefits
- Unemployment Benefits
- Alimony
- Worker's Compensation
- Income from Rent or Room / Board
- Military Pay
- Veterans Benefits
- Interest, Dividends or Royalties
- Pensions or Annuities

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## **Do not include the following types of income:**

- Supplemental Security Income (SSI)
- Public Assistance Grants
- Foster Care Payments
- Earned Income of Household Members Under Age 21 (other than the applicant)
- Educational Grants and Loans
- In-kind Maintenance (such as rent, groceries, etc.)
- Child Support Payments

Note: Sole Proprietors should deduct their monthly business expenses in calculating their monthly income.

## SECTION C. HEALTH INSURANCE INFORMATION

**Question 1** – If you are currently covered under other health insurance that offers both medical and hospital benefits, check “Yes.” If you are currently covered under other insurance that offers only hospital or only medical (doctors office visits) benefits, check “No.” If your current insurance provides limited benefits such as vision-only, dental-only or hospital-only benefits, etc., then check “No.”

**Question 2** – If you were covered under other health insurance within the past 12 months and that other insurance provided both hospital and medical benefits, check “Yes.” If you had other insurance within the past 12 months, but it did not cover both hospital and medical expenses, check “No.” If you did not have any other insurance within the past 12 months, check “No.”

If you answered Question 2 as “No,” skip Question 3 and go to Question 4.

**Question 3** – If you answered Question 2 as “Yes,” check the reason(s) why your other health insurance coverage terminated or will terminate. Check all that apply.

**Question 4a** – If your employer offers health insurance that provides both medical and hospital benefits and you are eligible to receive such coverage through your employer, then check “Yes.” If your employer offers health insurance to other employees, but you are not eligible for it, check “No.” If your employer does not offer any health insurance coverage, check “No.” If your employer offers coverage that provides limited benefits (less than both medical and hospital benefits), check “No.”

**Question 4b** – If your employer contributes towards the cost of the health insurance, check “Yes.” If you are required to pay the full cost of your health insurance, check “No.”

**Please note** – If your employer offers both medical and hospital health insurance coverage and contributes toward the cost of such insurance, you are not eligible for Healthy New York coverage.

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## SECTION D. EMPLOYMENT

Please check if “You” or your “Spouse” is currently employed, either on a full-time or part-time basis, or if you or your spouse is self-employed. Otherwise, check “Neither.”

If you checked “You” or your “Spouse” above, then skip this question. Otherwise, if your answer to the question above was “Neither,” then indicate whether or not you or your spouse were employed for some portion of the 52 weeks preceding application . You may include seasonal employment, periodic work assignments and other intermittent employment.

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

## SECTION E. DOCUMENTATION

You must attach documents which show proof of your employment status or status as an individual proprietor, proof of New York state residency and proof of income. Examples of acceptable forms of documentation include:

Employment Status	NYS Residence	Income
<ul style="list-style-type: none"><li>• Pay stubs</li><li>• W-2s</li><li>• Letter from employer</li><li>• Documentation sufficient to demonstrate selfemployment</li><li>• Other (please explain)</li></ul>	<ul style="list-style-type: none"><li>• Utility bill</li><li>• Postmarked mail with address</li><li>• Letter/lease/rent receipt with home address from landlord</li><li>• NYS Driver’s License</li><li>• Property Tax Records or Mortgage Statement</li><li>• Other (please explain)</li></ul>	<ul style="list-style-type: none"><li>• Pay stubs</li><li>• W-2 forms</li><li>• Tax returns</li><li>• Letter from employer</li><li>• Business Records</li><li>• Award letters/benefit checks</li><li>• Other (please explain)</li></ul>

You may be asked to submit documentation for other information, including other health insurance.

## SECTION F. CERTIFICATION

Read the certification carefully. You (the applicant) must certify that the statements made in the application are true to the best of your knowledge. Also included in this section is a fraud warning statement. Please sign and date where indicated.