Healthy NY Annual Re-certification for Individuals and Sole Proprietors

Please read this form carefully, complete the requested information, and return it to the HMO you are enrolled with. Please provide the most current information.

This is your annual re-certification form for Healthy NY. In order to maintain your health insurance through the Healthy NY program, you must complete this form, showing that you continue to meet the program's guidelines. If you no longer meet the guidelines of the program, ask your HMO about other options for health insurance coverage.

I. Member Information

Name First	Middle		Last
Member I.D. Number			Telephone No.
Street Address (where you live) Street			
City	State	Zip	County
Mailing Address if different than street address Street			
City	State	Zip	County

II. Medicare Eligibility

Anyone who is eligible for Medicare will lose their eligibility for Healthy NY. Is anyone to be covered under the policy also eligible for Medicare? ______ **NO** _______ **YES**

If yes, please write the name of the person here ___________________________________

III. Choice of Benefits

Healthy NY is available either **with** prescription drug coverage (up to $3,000 per person annually) **or** **without** prescription drug coverage. Once you select your choice of benefits, you cannot change your benefit package for a year. **You may change benefit plans only at the time of annual re-certification**. **Please circle the "Y" next to your choice for your benefit plan**:

Y Healthy NY with prescription drug coverage
(max $3,000 per person, $100 deductible)

Y Healthy NY without drug coverage

IV. Family Size

The allowable income limit depends upon the number of family members you have. Please include you, your spouse (if residing in your household), and dependent children. Do not count any other members of your household. Pregnant women count as two people for determining family size.

Family Size = _________.

V. Income Information

Please list your current monthly gross income and the current monthly gross income of your spouse (if your spouse resides in your household). **Do not** count the income of anyone else in your household.

- **Income includes:** 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.

(Please Note: Sole Proprietors may subtract monthly business expenses from their monthly income.)

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

Your household income must meet the following guidelines in order to continue in the HNY program.

Healthy NY Household Income Guidelines*

Family Size	Monthly Income at or Below
1	$ 1,940
2	$ 2,603
3	$ 3,265
4	$ 3,928
5	$ 4,590
Each additional person add:	$ 663

*Effective 01/04

VI. Certification – Please read carefully.

By signing this certification of eligibility, I certify under penalty of perjury that:

- I am a resident of New York State, and
- that all individuals to be covered under my policy are ineligible for Medicare, and
- all statements contained in this certification are true to the best of my knowledge.

Date______________ Signature____________________________________

Fraud Warning: 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.