Employer Application

Applications for the FHP Employer Buy-In must be submitted to NYSDOH at least three months prior to expected date of coverage.

Employer Information

Employer Name: ____________________ Employer Tax ID: ____________

Name & Title of Employer Representative: ____________________

Employer Address: ____________________

Employer Phone: ____________ Employer Fax: ____________ E-mail Address: ____________

Insurance Information

Name of Current Insurer (if any): ____________ Number of Years Offering Coverage: ______

What is the current employee premium? ____________________

What is the employee premium contribution for health insurance coverage? ____________

FHP Buy-In Election

What health plan have you selected for Employer Buy-In insurance coverage? ____________

Percent of Employer Contribution (must be at least 70%)? ____________

Will the health plan provide dental coverage? ☐ Yes ☐ No

Employee Demographics

Total number of employees: Male _____ Female _____

Total number of employees eligible for health insurance coverage: ____________

Age breakdown of employees: 18-24 _____ 25-34 _____ 35-44 _____ 45-64 _____ Over 64 _____

Do all employees work or reside in New York State? ☐ Yes ☐ No

Describe employee requirements for benefit eligibility: ____________________

____

Is there an employee waiting period? ☐ Yes ☐ No If yes, how long? ____________

Signature

I agree to offer the State sponsored Employer Buy-In program to all employees as the sole health benefit option available through the employer. I further agree to reimburse the selected health plan the appropriate premium for all employees, including the employee contribution. I understand that the State will pay up to 30% of the total premium to cover the employee contribution amount for certain employees who meet specific eligibility requirements. I further agree to comply with all information requests and timeframes as specified by the State.

____________________ Employer Representative Signature

____________________ Date of Application

____________________ Print Name

____________________ Title of Representative