



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 or Designated Sponsor (DS) Name: _____ Employer Tax ID: _____

Name & Title of Employer Representative:

Employer Address:

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

Insurance Information

Do you currently offer health insurance to employees? Yes No

If yes, what percentage of your payroll do you currently pay toward employee health insurance costs? _____

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 employer or DS 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 _____