Hometown Health

HEALTH INSURANCE APPLICATION CHECKLIST

APPLICATION WILL NOT BE CONSIDERED COMPLETE WITHOUT THE REQUIRED DOCUMENTATION LISTED BELOW.

Please be aware that rates are subject to change based on final information and census.

Business Name _____ Effective Date _____

ALL APPLICANTS

- ☐ **Completed application and plan selections**
- ☐ **Current Nevada State Business License or Notice of Exemption letter from Nevada Secretary of State**
- ☐ **Completed Common Ownership Attestation**
- ☐ **Completed Business Attestation** *(Partnerships Only)*
- ☐ **Enrollment application, electronic enrollment application, or enrollment file for electronic eligibility**
- ☐ **Estimated 1st month premium binder check**
  - Any discrepancy between the binder amount and the final enrollment will be billed or credited on the first premium bill.

BUSINESSES WITH "W-2" EMPLOYEES

- ☐ **Most recent filed State Wage & Quarterly**
  - Businesses in operation less than three months must submit Articles of Incorporation along with two weeks of payroll in lieu of the State Wage & Quarterly.
- ☐ **Two weeks of payroll receipts for employees that do not appear on the group's State Wage & Quarterly**
  - Business Verification Form maybe submitted in lieu of payroll at Underwriting's approval
- ☐ **Waiver of Health Coverage Benefits for all Eligible Employees who are waiving coverage or who are eligible for and/or participating in COBRA. "Eligible Employee" means a permanent employee who has a regular working week of 30 or more hours**

BUSINESSES WITH OWNERS THAT DO NOT APPEAR ON THE STATE WAGE & QUARTERLY

PROVIDE AT LEAST ONE ITEM FROM THE LIST BELOW

- ☐ **Partnership Business Type** – US Return of Partnership Income Form 1065 *(Schedule K-1)*
- ☐ **S Corporation Business Type** – US Return of Shareholder Income Form 1120S *(Schedule K-1)*
- ☐ **Limited Liability Company (LLC) with Partners** – Form 1065 *(Schedule K-1)*

Hometown Health

HEALTH INSURANCE APPLICATION CHECKLIST

DOCUMENTATION REQUIREMENTS FOR EACH BUSINESS TYPE.

Business Type	In business more than 3 months	In business less than 3 months
C CORPORATION	Nevada Employer's Quarterly Contribution and Wage Report	Payroll records and Articles of Incorporation
S CORPORATION	Nevada Employer's Quarterly Contribution and Wage Report or K-1 for shareholder's income	Payroll records and Articles of Incorporation
PARTNERSHIP	K-1 for partner's income or Schedule SE (self-employment tax) or Form 1065 Partnership Return and Nevada Employer's Quarterly Contribution and Wage Report for employees.	Partnership Agreement and SS-4 (application for tax id) and payroll records
LIMITED LIABILITY COMPANY (LLC)	May file as either a C Corporation or a Partnership (refer to above)	May file as either a C Corporation owner or a Partnership (refer to above)

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Adoption Agreement & Eligibility Attestation for Association Health Plan Employer Group Enrollment

Groups that are new to this Association must complete this entire application.
Groups that are renewing must complete this page and any section that has changed from the previous year's application.

This ADOPTION AGREEMENT & ELIGIBILITY ATTESTATION FOR ASSOCIATION HEALTH PLAN EMPLOYER GROUP ENROLLMENT ("Agreement") in the association health plan program provided by the Manufacturing Benefit Trust Fund or the Service Benefit Trust Fund ("Association"), as applicable, is hereby submitted by the following Employer Group:

1. FULL LEGAL NAME OF EMPLOYER GROUP

2. LOCATION ADDRESS

Street City State Zip Code

3. REQUESTED EFFECTIVE DATE (first of a month) ASSOCIATION GROUP ID

All days begin and end at 12:00 midnight. All initial and renewal terms will be 12 months

I certify and attest that Employer Group desires to enroll in the association health plan offered by the applicable Association indicated below, that Employer Group agrees to the terms of this Agreement and to the terms of the Policy and that:

1. Employer Group is a bona-fide business establishment that meets and will continue to meet all participation requirements, including continued membership in the Carson City Chamber of Commerce.
2. This Agreement authorizes Association, or its authorized representative, to audit applicable records, no more than one time annually, to confirm that Employer Group meets the eligibility requirements. Such audit shall not cause undue burden on Employer Group. Employer Group may require Association, or its authorized representative, as applicable, to sign reasonable confidentiality agreements.
3. Employer Group understands that Association and/or its contracted insurer has the right to accept or reject the application for association health plan coverage. Coverage will not commence until the application has been accepted.
4. Employer Group understands and agrees to distribute all plan documents consistent with Association's Guidelines for SPD Distribution, abide by the eligibility rules applicable to employee and dependent enrollment, COBRA continuation of coverage notice requirements, regardless of the number employees employed by Employer Group, and payment rules as provided in the approved Plan, this Agreement and the Policy and that this Agreement can only be revised at renewal in writing.
5. Employer Group understands that all association health plan coverage under this Agreement, including any coverage for individuals covered under COBRA continuation of coverage, may be terminated if Employer Group fails to pay the applicable monthly fees as billed by the due date or completion of the grace period, as applicable.
6. Employer Group will fully defend, indemnify and hold harmless Association and its trustees, employees, consultants and administrators against any and all loss, damage, liability, claim, demand or suit resulting from injury or harm to any person or property arising out of or in any way connected with the participation of the Employer Group under this Agreement. This is intended to include, but is not limited to, employment-related claims, statutory violations, breach of contract claims and claims for damages resulting from personal injury or injury to property.
7. Employer Group understands this Agreement can only be revised at renewal in writing and that Employer Group will comply with the Association's policies and procedures as well as the Trust Agreement as it may be revised in the future.
8. The undersigned representative of Employer Group has reviewed the above information and agrees to its accuracy.

Print name and title of **Employer Group** representative

Signature of **Employer Group** representative (cannot be group's insurance broker) Date

Producer Title, Name & Agency

Producer Signature Date

☐ Manufacturing Trust ☐ Service Trust

For Hometown Health use only:
Approved effective date: _____
Parent code: _____

Manufacturing and Service BTF Sponsored by the Carson City Chamber of Commerce

Adoption Agreement & Eligibility Attestation
for
Association Health Plan Employer Group Enrollment

If you are renewing coverage and have no changes to any information on the following pages,
Stop here.

If you are renewing coverage, but information requested on the following pages has changed,
Please fill out those sections that have changed.

If you are applying for coverage under this Association for the first time,
Please complete the remainder of the application in its entirety.

4. TAX INFORMATION:
4a. Federal Tax ID #: _____ 4b. IRS Section 125: ☐ YES ☐ NO

4c. Year Business Established _____

5. MAILING ADDRESS (if different from the location listed in item 2 above):

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

6. NAME & TITLE OF OWNER, GENERAL MANAGER OR CEO:

_____
Name Title

Telephone: _____ Fax: _____ Email: _____

7. COMPANY BILLING NAME AND ADDRESS (If different from legal name in item 1 above):

_____
Name

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

8. BUSINESS INDUSTRY OR NATURE OF BUSINESS:

_____ _____
Description NAICS Code (**REQUIRED** on initial app)

9. COMPANY TYPE: ☐ Corporation ☐ LLC ☐ Non-profit ☐ Partnership ☐ S–Corp.
☐ Political Subdivision ☐ Union ☐ Sole Proprietor ☐ Other: _____

10. COMPANY SIZE:
10a. #Employees (FT & PT): _____ 10b. #Employees Eligible To Enroll: _____ 10c. #Employees Waiving Enrollment: _____
10d. Please check appropriate box below to indicate your organization's size:
☐ Less than 20 full- or part-time employees*
☐ 20 to 99 full- or part-time employees*
☐ 100 or more full- or part-time employees*
* If organization represents multiple employer groups, please count employees in other groups also.

11. EMPLOYEES BY COUNTY
Enter the number of employees eligible to enroll that live in the following areas (total should equal 10b above):
1 – Clark & Nye: _____ 2 – Washoe: _____ 3 – Carson, Douglas, Storey, and Lyon: _____
4 – All other Nevada: _____ 5 – All other out of state: _____

12. OTHER COVERAGE:
Does your company offer other insurance options (i.e. dental/vision) not associated with Hometown Health? ☐ YES ☐ NO
13a. If Yes:
Coverage Type: _____ Carrier Name: _____
Coverage Type: _____ Carrier Name: _____

13. EMPLOYER CONTRIBUTION:
Enter the percentage (%) or dollar ($) amount (minimum is 50% of total funding requirement):

Hourly Employees	Salaried Employees	Other (Please specify):
Employees: _____	Employees: _____	Employees: _____
Dependents: _____	Dependents: _____	Dependents: _____

14. CORPORATE CONTACT:

Name Title

Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

15. LOCAL CONTACT (If same as corporate contact, leave blank):

Name Title

Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

16. PREMIUM BILLING CONTACT (If same as corporate or local contact, leave blank):

Name Title

Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

17. OTHER CONTACT (If applicable):

Name Title

Telephone: _____ Fax: _____ Email: _____

18. EMPLOYEE ELIGIBILITY:
All employees who meet the waiting period requirement and who work at least 30 hours per week are eligible. Additionally, those employees who are on Family Medical Leave Act (FMLA) leave are eligible.

19. DEPENDENT ELIGIBILITY:
- ☐ Employee Only
- ☐ Employees and dependent children
- ☐ Employees, spouse and dependent children
- ☐ Employees, spouses, domestic partners and dependent children

20. WAITING PERIOD

Eligible employment begins on:
- ☐ On the date of hire (default).
- ☐ Following a reasonable and bona fide employment-based orientation period of ____ days (not to exceed 30 days).

Eligible employment also begins when a part time employee transitions to full time.

Salaried	Hourly	Other (Please list)	Once eligible employment begins as described above, employee *coverage* begins:
☐	☐	☐ :	☐ 1st of the month on or following date of eligible employment
☐	☐	☐ :	☐ 1st of the month on or following ____ day(s) of eligible employment (60 days max)
☐	☐	☐ :	☐ 1st of the month on or following 1 month of eligible employment

21. REHIRE POLICY:

This section only applies to employees that were covered under the employee health plan on the date of termination of the immediately previous employment period.
- ☐ Does not apply (default – rehire policy will default to newly eligible employee provisions)
- ☐ If rehired within ____ days (365 days max) then coverage effective on the 1st of the month following rehire.
- ☐ If rehired within ____ months (12 months max) then coverage effective on the 1st of the month following rehire.

22. COVERAGE BEGIN AND END:

Employee coverage always begins on the first of the month. Dependent coverage always begins on the first of the month, except in the case of birth, adoption or placement for adoption, in which case coverage begins on the date of the event and in the case of loss of other coverage in which case coverage begins on the day after loss of coverage. Coverage always ends on the last day of the month in which the employee ceases to be eligible, except in the case of death.

23. PAYMENT PROVISIONS:

If coverage begins on: The 1st through the 15th of the month – FULL PREMIUM and HEALTH PLAN FUNDING DUE
The 16th through the end of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE

If coverage ends on: The 1st through the 15th of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE
The 16th through the end of the month – FULL PREMIUM and HEALTH PLAN FUNDING DUE

24. PRODUCER OF RECORD (New producers contract Sales & Marketing at (775) 982-3100):

Company/Agency

Producer Name

25. SECOND PRODUCER OF RECORD (if applicable; new producers contract Sales & Marketing at (775) 982-310):

Company/Agency

Producer Name

☐ Split commission. Second producer of record will receive _____% (1-99%) of the commissions applicable to this employer group.

Hometown Health

COMMON OWNERSHIP CERTIFICATION

PLEASE COMPLETE, SIGN AND SUBMIT THE COMMON OWNERSHIP CERTIFICATION.

This form must be filled out and returned even if you do not have multiple companies.

Please list all employer groups that qualify under 26 USC Section 414(b) (c) (m) or (o) of the Internal Revenue Code.

COMPANY INFORMATION

Name of Employer Group _____

Business Owner _____

Primary Business Location _____

Name of Business Entity	Employer Federal Tax ID Number (FEIN)	Percentage of Ownership	Number of Full-Time Equivalent (FTE) Employees
1			
2			
3			
4			
5			
6			

- **A FULL-TIME EMPLOYEE** is an employee who is employed on average, per month, at least 30 hours of service per week, or at least 130 hours of service in a calendar month.
- **A FULL-TIME EQUIVALENT EMPLOYEE** is a combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee.
- **AN AGGREGATED GROUP** is commonly owned or otherwise related or affiliated employers, which must combine their employees to determine their workforce size.

I certify that the group named above is a single employer under section 414 of the Internal Revenue Code of 1986 (26 U.S.C. Section 414 (b), (c), (m), or (o)), and under any applicable state law. I further certify that there are no other affiliated entities other than the ones listed above who are eligible to file a combined state tax return. I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I understand that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Signature _____ Date _____

Relationship to company *(Please Check One of the Following)*

☐ Owner ☐ HR Rep ☐ Accountant for Employer ☐ Attorney representing employer

Hometown Health

ATTESTATION FORM

For Sole Proprietor or Business where the Owner is the Sole Employee

PARTNERSHIPS WITH NO EMPLOYEES

BUSINESS ORGANIZATION INFORMATION

Name of Organization _____

State Business License Number _____

Primary Business Activity _____

Address _____

City _____ State _____ Zip _____

CONTACT INFORMATION FOR BUSINESS ORGANIZATION

Last Name _____ First Name _____ Middle Initial _____

Title _____

Telephone _____ Fax _____

CHECK ONE BELOW

☐ **Sole Proprietor or Business where the Owner is the Sole Employee**

I hereby attest that: (i) I am the owner and operator of the above described business organization; (ii) I work a minimum of thirty (30) hours per week for this business organization; (iii) I (and my eligible dependents) am the only person eligible for health coverage through the above described business organization.

☐ **Partnership**

I hereby attest that: (i) I am one of the owners of the above described business organization and have the authority to enter into an agreement to purchase health insurance coverage on behalf of all of the partners of this business organization; (ii) the above business organization does not offer health insurance coverage to any of the partners through another company; (iii) the above business organization does not have any "W-2" employees; (iv) only the partners that work a minimum of thirty (30) hours per week for this business (and their eligible dependents) will seek health coverage through the organization.

☐ **None of the Above**

If the above does not describe you, check here; no signature is needed.

I agree to provide upon request appropriate tax forms to Hometown Health to validate the eligibility status. Before application will be approved, the applicant must execute this Attestation Form and provide the tax information and related documents indicated on the attached checklist. Hometown Health reserves the right to modify these documentation and eligibility requirements in the future. I agree to promptly advise Hometown Health in the event that any of the statements made in this Attestation are no longer accurate. The undersigned certifies that, to the best of his or her knowledge and belief, and under penalty of perjury, the information listed above is true and complete.

Signature of Applicant _____ Date _____

HOMETOWN HEALTH USE ONLY

G# _____

M# _____

L _____

F, M _____

Hometown Health

ENROLLMENT / CHANGE FORM

HUMAN RESOURCES ONLY

Employer _____ Group Number _____

Effective Date _____ Employee's Weekly Hours _____ Employee's Date of Hire _____

Employer Signature _____

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____

City _____ State _____ Zip _____ County _____

Physical Address _____

City _____ State _____ Zip _____ County _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation _____ Home Phone _____ Work Phone _____

PLAN ELECTED

*Street Address only, no P.O. Boxes

☐ HMO	☐ EPO	☐ PPO	☐ PPO w/HSA*
Plan Elected	**Plan Elected**	**Plan Elected**	**Plan Elected**

OTHER MEDICAL COVERAGE

Do you or any of your Dependents listed on the next page have Medical/Health Insurance (Including Medicare/Medicaid)?

☐ ***YES*** ☐ ***NO***

If yes, please provide copy of insurance card (front & back).

CONTRACT TERMINATION ONLY

Completion of this section will terminate coverage for subscriber and all dependents.

☐ Left Company ☐ Ineligible

☐ Deceased ☐ Dissatisfied

☐ Moved ☐ Other *(If other, explain below)*

_____

REASON FOR CHANGE

☐ New Hire ☐ PT/FT

☐ Name ☐ Reinstatement

☐ Annual Election ☐ Waive Coverage

☐ Rehire ☐ Retiree

☐ COBRA (18-29-36) ☐ Transfer

☐ Other *(If other, explain below)* ☐ Address

Plan Change From _____ To _____

ADD/DELETE DEPENDENT

☐ Marriage** ☐ Divorce**

☐ Birth/Adoption** ☐ Other**

☐ Loss of Dependent Status** ☐ Court Ordered/ Legal Guardianship**

☐ Loss of Insurance** ☐ Deceased**

***Attach legal documentation as proof of event.*

MEMBER INFORMATION – COMPLETE WITH NEW OR CHANGE INFORMATION

EMPLOYEE **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

SPOUSE **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

DEPENDENT CHILD (Relationship) **Action** ☐ Add ☐ Change ☐ Delete

Last Name** ______ First Name ______ Middle Initial ______

Social Security Number ______ Date of Birth (mm/dd/yyyy) ______

Sex ☐ Male ☐ Female **Reside with Employee?** ☐ ***YES*** ☐ ***NO***

Email Address ______ Primary Care Physician *(if required)*† ______

THIS SPACE IS FOR HOMETOWN HEALTH USE ONLY ______

***Attach legal documentation as proof of action (Add, Change or Delete).*
† It is member's responsibility to verify physician availability in their area.

ACKNOWLEDGMENT OF TERMS

Employee Signature ______ Date ______
See Next Page

Hometown Health

ACKNOWLEDGMENT OF TERMS

I understand and agree that, with the exception of emergency procedures, all services must be performed by a Hometown Health participating provider, or authorized in advance by Hometown Health, to be considered for payment at the in-network rate. Additional requirements may apply. See the appropriate plan documents for details.

I understand that I am responsible for paying any required deductibles, copayments, and coinsurance directly to the providers of healthcare at the time of service.

I agree to be bound by all terms of the plan under which I am applying for coverage for as long as I am covered under the plan.

I certify that, to the best of my knowledge, the information shown on the front of this form is correct.

I have read and understand the terms of this application.

My signature on the front of this form constitutes acceptance of the terms listed above.

Key to Plan Types

HMO Health Maintenance Organization
PPO Preferred Provider Organization
TPA Third Party Administrator for self-funded plan
HSA Health Savings Account

STATEMENT OF ACCOUNTABILITY

To be completed only when the applicant cannot complete the application
NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English
☐ Applicant does not write English ☐ Other *(Explain)* _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant ☐ Or by _____

I also translated and fully explained the "Application Understandings, Conditions and Agreement," and "Payment Method."

Translator Signature *(Required)* _____ Date *(Required)* _____

I confirm that the application was translated on my behalf.

Applicant Signature *(Required)* _____ Date *(Required)* _____
Language interpreted *(e.g. Spanish)* _____

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Hometown Health

WAIVER OF HEALTH COVERAGE BENEFITS

All the sections on this form must be completed and signatures are required from employee and employer.

SEE INSTRUCTIONS ON PAGE 2

EMPLOYER INFORMATION

Name of Employer _____

Address _____

City _____ State _____ Zip _____

Telephone _____

APPLICANT / EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Date of Hire _____ Job Title _____

OTHER COVERAGE INFORMATION

Do you have other health benefit coverage?

☐ ***YES*** – If Yes, please complete below

☐ ***NO*** – I do not have other health insurance coverage

Coverage Information

Name of primary person on policy _____

Name of Employer or the Party providing health care coverage _____

Name(s) of dependent(s) covered on policy _____

Name of health plan provider / insurer _____

PLEASE ATTACH A PHOTOCOPY OF YOUR HEALTH PLAN PROVIDER ID CARD.

VALIDATION OF WAIVER OF BENEFITS

*I understand that I have been offered group health insurance by my employer, with Hometown Health. I have elected **NOT** to enroll myself, and/or my dependent(s). I understand that if I and/or my dependent(s) decide, at some time in the future, that I (we) desire this coverage, I must wait for my employer's "open enrollment' period, or special enrollment period due to qualifying event. (i.e.: Divorce, marriage, birth of child, death, loss of medical insurance, etc).*

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Comments _____

Hometown Health

INSTRUCTIONS

ALL THE SECTIONS ON THIS FORM MUST BE COMPLETED
and signatures are required from employee and employer.

EMPLOYER INFORMATION

1. Enter company data in the appropriate Employer information areas.

APPLICANT / EMPLOYEE INFORMATION

1. Enter your personal data in the appropriate Applicant / Employee information areas.

OTHER COVERAGE INFORMATION

1. Please indicate if you do or do not have other health benefit coverage.
2. Please indicate the name of both the Employer, the primary member holding this insurance coverage and the insurance carrier providing you and/or your dependents with the coverage.
3. Attach a photocopy of the Plan Provider ID card.

VALIDATION OF WAIVER OF BENEFITS

1. **EMPLOYEE**
   Read the statement carefully, then sign and date the Waiver of Coverage Form. Please return the form to your employer.
2. **EMPLOYER**
   Please sign form before returning to Hometown Health.

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