New Large Group Sold Checklist

Group Name:_____Effective Date:_____

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

Hometown Health Enrollment Form or Electronic Enrollment

Hometown Health Waiver of Health Coverage

- **For any eligible employee (**"Eligible employee" means a permanent employee who has a regular working week of 30 or more hours *NRS689C.065)*

Hometown Health Group Application & Eligibility Guidelines

Medical Assessment Forms, If Required

Hometown Health

10315 Professional Circle, Reno, NV

MEDICAL ASSESSMENT FORM

(ONLY VALID FOR 60 DAYS)

"ALL QUESTIONS ON **FRONT AND BACK** MUST BE ANSWERED"
PLEASE FILL OUT FORM IN INK – NO WHITE OUT
ORIGINALS ONLY – NO FAX

EMPLOYEE INFORMATION

Business Name_____ Business Phone (_____) _____ - _____

Home Address of Employee_____
City State Zip

Mailing Address of Employee_____ Home Phone (_____) _____ - _____
City State Zip

Full-time Employment Date _____ Job Title_____ Job Duties _____ Hours worked per week for this firm _____

A. LIST ALL FAMILY MEMBERS TO BE INSURED

	(First) (Middle) (Last)	SEX M/F	Date of Birth Month/Day/Year	Height	Weight	Social Security Number	If last name different explain relationship*
Employee						- -	☐ Married ☐ Single
Spouse						- -	
Child						- -	
Child						- -	
Child						- -	
Child						- -	

** If last name is different from employee, legal documentation must be provided. If additional space is needed, attach, **date and sign** a separate sheet.*

B. THE FOLLOWING QUESTIONS MUST BE ANSWERED ACCURATELY AND COMPLETELY

Has any person applying for coverage, including dependents, *ever at any time* had, been told of having, consulted a physician or practitioner, or taken medication for any of the following: *(If "yes", please circle condition and complete Section C.)*

	EMPLOYEE	DEPENDENT
1. Diabetes? (check one) ☐ Diet, ☐ Oral, ☐ Insulin	YES NO ☐ ☐	YES NO ☐ ☐
2. Cancer, Leukemia, Hodgkin's Disease or any form of Malignancy?	YES NO ☐ ☐	YES NO ☐ ☐
3. Kidney Disease, Renal Failure and/or currently on Dialysis? Have you been diagnosed with Hepatitis (check one) ☐ A, ☐ B, ☐ C or ☐ ___ , Alcoholism, Drug Abuse, Cirrhosis of the Liver, Asthma, TB, Emphysema, COPD or any type of Respiratory Disease? Used Tobacco during past 12 months (Amount per day? _____ Number of Years Smoking/Chewing? _____)	YES NO ☐ ☐	YES NO ☐ ☐
4. HIV or AIDS, Epilepsy, Cerebral Palsy, Multiple Sclerosis, Back/Neck/Spinal Disorder, Rheumatoid Arthritis, Ulcerative Colitis, Intestinal Disorder, Heart Attack, Heart Disease or Disorder, Aneurysm, Stroke, Mitral Valve Prolapse, Lupus or Arteriosclerosis?	YES NO ☐ ☐	YES NO ☐ ☐
5. Have you or any of your dependents ever had a transplant or been advised to have a transplant? If so, which organ?_____	YES NO ☐ ☐	YES NO ☐ ☐
6. Been advised within the past year to have Surgery or to be Hospitalized for any condition?	YES NO ☐ ☐	YES NO ☐ ☐
7. Are you or your dependents (including children) currently Pregnant? If yes, Due Date: _____ Have you or any of your dependents had any Complications of Pregnancy including Caesarean Section and/or Premature Delivery or have been or are being treated for Infertility?	YES NO ☐ ☐	YES NO ☐ ☐

C. IF ANSWER IS "YES" TO ANY OF THE QUESTIONS IN SECTIONS B, GIVE COMPLETE DETAILS BELOW (Write N/A if not applicable):

Question Number	Person	Medical Condition	Treatment/Medication (For Drug/Alcoholism or Tobacco provide date and duration of last consumption below)	Dates Treated or Consulted with Doctor FROM MO/YR TO MO/YR	Degree of Recovery

*If additional space is needed, attach, **date and sign** a separate sheet.*

Please provide **COMPLETE** names and addresses of all attending doctors, hospitals and clinics and the medical condition for which treatment was received.

_____ _____ (_____)_____-_____ _____
Name of Doctor (including Family Practitioner)/Hospital/Clinic Address Phone Number Medical Condition

_____ _____ (_____)_____-_____ _____
Name of Doctor (including Family Practitioner)/Hospital/Clinic Address Phone Number Medical Condition

Signature of Employee: _____ Date: _____ Signature of Spouse:_____ Date: _____

E. IMPORTANT — APPLICANT'S STATEMENT — *PLEASE READ CAREFULLY*:

I represent that all answers given, including those on the front of this application, are full, complete and true to the best of my knowledge, information and belief. When applicable, I authorize my employer to deduct premiums from my earnings. I understand that any material misstatement or failure to provide requested information may be used as a basis of termination of my coverage. I understand that no coverage will be effective until this application has been approved by HHP. I understand that this information is not valid after 60 days from completion.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the insurer or their legal representatives, any and all such information.

I understand the information obtained by use of the authorization will be used to evaluate the overall medical risk of the group coverage and ascertain any pre-existing conditions, if applicable. Any information obtained will not be released by the administrator to any person or organization except to insuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I acknowledge that information to be released may include alcohol and/or drug abuse or psychiatric information that is protected by Federal regulations; my signature authorizes release of such information.

I further acknowledge that information to be released may also include HIV test results and/or Acquired Immune Deficiency Syndrome diagnosis.

I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for two and one half years from the date shown below.

Signature of Employee: _____ Date: _____ Signature of Spouse:_____ Date: _____

Any information disclosed cannot be used to deny group medical coverage.

Rev. Nov 2015

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
☐ Deceased
☐ Moved
☐ Ineligible
☐ Dissatisfied
☐ Other *(If other, explain below)*

_____

REASON FOR CHANGE

☐ New Hire
☐ Name
☐ Annual Election
☐ Rehire
☐ COBRA (18-29-36)
☐ Other *(If other, explain below)*
☐ PT/FT
☐ Reinstatement
☐ Waive Coverage
☐ Retiree
☐ Transfer
☐ Address

Plan Change From _____ To _____

ADD/DELETE DEPENDENT

☐ Marriage**
☐ Birth/Adoption**
☐ Loss of Dependent Status**
☐ Loss of Insurance**
☐ Divorce**
☐ Other**
☐ Court Ordered/ Legal Guardianship**
☐ 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)* _____

10315 Professional Cir. • Reno, NV 89521 • 775-982-3232 • hometownhealth.com

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.

10315 Professional Cir. · Reno, NV 89521 · 775-982-3232 · hometownhealth.com

Hometown Health

GROUP APPLICATION – INFORMATION DOCUMENT

This document will be requested to be reviewed annually at the health plan renewal period.

1 Full Legal Name of Contract Holder *(Include punctuation and abbreviations)*

Last Name _____ First Name _____ Middle Initial _____

1a. Federal Tax ID Number _____ **1b.** IRS Section 125 ☐ ***YES*** ☐ ***NO***

2 Address

Physical Address _____

City _____ State _____ Zip _____

Mailing Address *(If different – Street or PO Box)* _____

City _____ State _____ Zip _____

2a. Telephone _____ **2b.** Fax _____ **2c.** Email _____

3 Name / Title of Owner, General Manager or CEO

Name _____ Title _____

3a. Telephone _____ **3b.** Fax _____ **3c.** Email _____

4 Company Billing Name and Address *(If Different from Legal Name Noted Above)*

Company Billing Name _____

Physical Address _____

City _____ State _____ Zip _____

Mailing Address *(If different – Street or PO Box)* _____

City _____ State _____ Zip _____

4a. Telephone _____ **4b.** Fax _____

5 Business Industry or Nature of Business _____

6 NAICS Code *(If available)* _____ **6a.** Member of Builders Association ☐ ***YES*** ☐ ***NO***

7 Company Type

- ☐ Corporation
- ☐ LLC
- ☐ Non-Profit
- ☐ Partnership
- ☐ Other _____
- ☐ Political Subdivision
- ☐ S Corp.
- ☐ Sole Proprietorship
- ☐ Union

8 Year Business Established _____

8a. Number of Employees *(FT & PT)* _____

8b. Number of Employees Eligible To Enroll _____

8c. Number of Employees Waiving Enrollment _____

8d. 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**

**Mandatory Insurer Reporting Law-Section 111 of Public Law 110-173*

***If organization is part of a multi-employer plan (a group of plans), please count employees in other groups/plans also.*

9 Does Your Company Offer Other Insurance Options, Not Associated With Hometown Health?

☐ ***YES*** ☐ ***NO*** *(e.g. Dental and/or Vision)*

9a. If Yes, please list below

Coverage Type _____

Carrier Name _____

Coverage Type _____

Carrier Name _____

AREA FOR HOMETOWN HEALTH USE ONLY

Effective Date _____

Parent Code _____

10 Employer Contribution to Employee and Dependent Premium

Enter the Percentage or Dollar Amount;
Minimum is 50% of Employee Premium

Hourly	**Salaried**	**Other** *(Please specify)* _____
EE ____	EE ____	EE ____
DEP ____	DEP ____	DEP ____

Hometown Health

GROUP INFORMATION

A COMPANY INFORMATION

1a. Company Name _____

B COMPANY BENEFIT ADMINISTRATOR(S)

1b. Corporate Contact

Last Name _____ First Name _____ Middle Initial _____

Title _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

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

2b. Local Contact *(If Same as Corporate Contact, Leave Blank)*

Last Name _____ First Name _____ Middle Initial _____

Title _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

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

3b. Premium Billing Contact *(If Different than Contacts Listed Above)*

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

4b. Other Company Contacts *(If Applicable)*

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

Hometown Health

GROUP ELIGIBILITY AND PAYMENT PROVISIONS

Please return with renewal/new packet.

A Company Name _____ Group Size _____

Check categories in each Provisions Section: **B – Eligibility Status** and **C – Commencement of Coverage**

B ELIGIBILITY STATUS *(Check All Categories Applicable)*

Salaried	Hourly	Other *(Please List)*
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____

1b. Eligible Employees:

☐ Active Employees ☐ Retirees
☐ Permanent Full Time Employees* ☐ Leave of Absence
☐ Other *(Attach Explanation)*

**Eligible employee means a permanent employee who has a regular working week of 30 or more hours.../NRS689C.065*

2b. Dependent Policy

☐ Employee Only (available for Employers with fewer than 50 full-time equivalent Employees)
☐ Employees and dependent children
☐ Employees, spouse and dependent children
☐ Employees, spouses, domestic partners and dependent children

C COMMENCEMENT OF COVERAGE *(Check All Categories Applicable)*

ELIGIBLE EMPLOYMENT BEGINS ON

☐ Date of Hire *(Default)*

OR

☐ Following a reasonable and bona fide employment-based orientation period of _____ days (not to exceed 30 days).
By selecting this box you attest that the orientation period you require is both reasonable and bona fide.
Eligible employment also begins when a part time employee begins to work full time.

Salaried	Hourly	Other *(Please List)*
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____
☐	☐	☐ _____

1c. Newly Eligible Employees Effective For Coverage

☐ 1st of Month on or following date of eligible employment
Termination of Coverage = Last day of month which employee ceases to be eligible

☐ 1st of Month OR following _____ day(s) of eligible employment (60 days max)
Termination of Coverage = Last day of month which employee ceases to be eligible

☐ 1st of Month on or following 1 month of eligible employment
Termination of Coverage = Last day of month which employee ceases to be eligible

☐ Additional Information *(Attach Explanation)*
Termination of Coverage = _____

LARGE EMPLOYERS ONLY HAVE THE FOLLOWING ADDITIONAL OPTIONS

☐ Date of eligible employment
Termination of Coverage = Midnight, the date of termination

☐ _____ ☐ days OR ☐ months from date of eligible employment (90 days max)
Termination of Coverage = Midnight, the date of termination

☐ Other *(Attach Explanation)*
Termination of Coverage = Last day of month which employee ceases to be eligible

2c. Newly Eligible Dependents – Births and Loss of Coverage Will Always be Date of Event

☐ 1st of Month following Date of Eligibility/Event ☐ Date of Eligibility/Event ☐ Other *(If other, explain below)*

Hometown Health

C COMMENCEMENT OF COVERAGE *(Continued)*

If this section is not addressed, policy will default to Newly Eligible Employee Provision

3c. Part Time to Full Time Policy

Only applies to large groups

☐ Does Not Apply

Minimum Number of _____ ☐ Days OR ☐ Months

WORKING P/T BEFORE GOING F/T, THEN COVERAGE EFFECTIVE

☐ Date of Full Time Status

☐ 1st of Month following Full Time Status

☐ Other (*Attach Explanation*)

If this section is not addressed, policy will default to Newly Eligible Employee Provision - only applies to employees covered prior to termination with current carrier.

4c. Rehire Employee Policy

☐ Does Not Apply

If Rehired within _____ ☐ Days OR ☐ Months of Termination then is Coverage Effective

Maximum period for rehire policy is 12 months

☐ Date of Rehire (Only applies to large groups)

☐ 1st of Month following Rehire

☐ Other (*Attach Explanation*)

D PAYMENT PROVISIONS

Full Monthly Premium	
IF COMMENCEMENT OF COVERAGE FALLS ON	The 1st through the 15th of the month - **FULL PREMIUM DUE** The 16th through the end the month - **NO PREMIUM DUE**
IF TERMINATION OF COVERAGE FALLS ON	The 1st through the 14th of the month - **NO PREMIUM DUE** The 15th through the end the month - **FULL PREMIUM DUE**

Updates and revisions to these provisions can ONLY be made at renewal date of health plan(s) and must by approved by carrier. All Changes must be submitted in writing. Authorized signature required below for approval of current provisions or changes made.

Print Name _____ Date _____

Print Title of Company Representative _____

Signature of Company Representative _____

Primary Contact _____ Email Address _____

Secondary Contact _____ Email Address _____

Notes _____

AREA FOR HOMETOWN HEALTH USE ONLY

Renewal Effective Date _____

Date _____ SSR _____ Section Changed _____ Effective Date _____

Hometown Health

PRODUCER STATEMENT

THIS SECTION MUST BE COMPLETED BY PRODUCER/AGENCY.

NOTE: Producer of Record MUST maintain a current State of Nevada Insurance Division License on file with our office. We must have appointed Producer through the State of Nevada Insurance Division prior to any payment of commission.

PRODUCER OF RECORD

Company / Agency _____

Producer Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

IRS Tax ID Number _____

SECOND PRODUCER OF RECORD *(If Applicable)*

Company / Agency _____

Producer Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Extension _____ Fax _____ Email _____

IRS Tax ID Number _____

COMMISSIONS

☐ Standard ☐ Net of Commissions ☐ None ☐ Split* Split Arrangement* _____

☐ Other _____

**If commissions are split or otherwise distributed, include a complete description of arrangements and information on ALL producers.*

MUST INCLUDE IRS TAX ID NUMBERS FOR ALL PRODUCERS OF SPLIT ARRANGEMENTS.

New Producer? ☐ Yes ☐ No

Producer must be appointed by Hometown Health

We/I certify that all information contained in this application is correct, to the best of my knowledge.
We/I also certify that:

1. This is a bona-fide business establishment, qualified association or trust.
2. This group meets all participation requirements
3. Coverage, enrollment provisions, eligibility requirements, benefits limitations and exclusions were fully explained and understood by the applicant/employer.
4. I/We know of no reason why coverage should not be offered and recommend that it be offered.
5. I am the Producer of Record representing this group/company.

Print Name _____ Date _____

Print Title of Company Producer _____

Signature of Company Producer _____

Hometown Health

EMPLOYERS STATEMENT

Company Name _____

1. I wish to enroll the above named company as a group account with:
   ☐ *Hometown Health Plan* (HMO) ☐ *Hometown Health Providers Insurance Co.* (PPO)
2. I understand and agree to abide by the eligibility rules applicable to employee enrollment as provided in the Evidence of Coverage (EOC).
3. I understand the participating requirements for specific coverage(s) and that those requirements must be met and maintained in order for the group to remain eligible for coverage.
4. I understand and agree to abide by the following prepayment requirement: Monthly prepayment fees are due and payable, in full, by the first day of the calendar month for which services are provided. Premium is delinquent if not received by the 15th of the month. Coverage will terminate on the last day of the month retroactive to the month for which payment is not received. Any other payment arrangements require our prior approval.
5. The group herewith tenders $ _____ and, in consideration of approval of the application, promises to pay any balance necessary to constitute the full initial payment for group benefits herein identified. It is understood that we have the right to accept or reject application. Coverage will not commence until the application has been accepted.
6. I understand that the Group Subscription Agreement (GSA) that includes the EOC, provides specific guidelines for administration of coverage.
7. The Group appoints the following Company / Agency as Producer of Record:
   Print Company / Agency _____
   Print Producer Name _____
8. To the best of our knowledge and belief, the information provided by the group is true and, along with the group application, is the basis for issuance of coverage and will become a part of the GSA.

Print Name _____ Date _____
Print Title of Company Representative _____

Signature of Company Representative _____

10315 Professional Cir. • Reno, NV 89521 • 775-982-3232 • hometownhealth.com