



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

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

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.

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




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**GROUP INFORMATION**


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**A COMPANY INFORMATION**
**1a. Company Name** \_\_\_\_\_
 

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 .....

**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 \_\_\_\_\_



**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:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Active Employees	<input type="checkbox"/> Retirees
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Permanent Full Time Employees*	<input type="checkbox"/> Leave of Absence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Other (Attach Explanation)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	*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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> 1st of Month on or following date of eligible employment <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> 1st of Month OR following _____ day(s) of eligible employment (60 days max) <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> 1st of Month on or following 1 month of eligible employment <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Additional Information (Attach Explanation) <i>Termination of Coverage =</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<b>LARGE EMPLOYERS ONLY HAVE THE FOLLOWING ADDITIONAL OPTIONS</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Date of eligible employment <i>Termination of Coverage = Midnight, the date of termination</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____ days OR <input type="checkbox"/> months from date of eligible employment (90 days max) <i>Termination of Coverage = Midnight, the date of termination</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Other (Attach Explanation) <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>	

**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)



**C COMMENCEMENT OF COVERAGE** (Continued)

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

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.

**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)

**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 - <b>FULL PREMIUM DUE</b> The 16th through the end the month - <b>NO PREMIUM DUE</b>
IF TERMINATION OF COVERAGE FALLS ON	The 1st through the 14th of the month - <b>NO PREMIUM DUE</b> The 15th through the end the month - <b>FULL PREMIUM DUE</b>

**Updates and revisions to these provisions can ONLY be made at renewal date of health plan(s) and must be 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 \_\_\_\_\_



**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 \_\_\_\_\_



**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 \_\_\_\_\_