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 Employer Group *(Contract Holder)*

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 the Month on 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

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

☐ Date of Rehire (Only applies to large groups)

☐ 1st of Month following Rehire

☐ Other (*Attach Explanation*)

Maximum period for rehire policy is 12 months

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 Plan* (EPO)
   - ☐ *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