ASSOCIATION HEALTH PLAN 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 or one-time payment form**
  - 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)*

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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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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

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. Doing Business As _____

1b. Federal Tax ID Number _____ **1c.** 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 Business Industry or Nature of Business _____

5 NAICS Code *(If available)* _____ **5a.** NAICS Description _____

6 Company Type

☐ Corporation ☐ Non-Profit ☐ Political Subdivision ☐ Sole Proprietorship

☐ LLC ☐ Partnership ☐ S Corp. ☐ Union

☐ Other _____

7 Year Business Established _____

7a. Number of Employees *(FT & PT)* _____

7c. Number of Employees Waiving Enrollment _____

7b. Number of Employees Eligible To Enroll _____

7d. 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.*

8 Does Your Company Currently Offer Health Insurance?

8a. If Yes, please list the carrier information below

8b. Does your company offer other insurance options? *(e.g. Dental and/or Vision)*

☐ ***YES*** ☐ ***NO*** If Yes, please list below

Coverage Type _____ Carrier Name _____

Coverage Type _____ Carrier Name _____

9 Employer Contribution to Employee and Dependent Premium

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

Hourly	**Salaried**	**Other** *(Please specify)* _____
Employee _____	Employee _____	Employee _____
Dependent _____	Dependent _____	Dependent _____

Hometown Health

GROUP INFORMATION

A COMPANY BENEFIT ADMINISTRATOR(S)

1a. 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

2a. 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

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

Last Name _____ First Name _____ Middle Initial _____
Address _____
City _____ State _____ Zip _____
Telephone _____ Extension _____ Fax _____ Email _____

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

Last Name _____ First Name _____ Middle Initial _____
Address _____
City _____ State _____ Zip _____
Telephone _____ Extension _____ Fax _____ Email _____

B GROUP PLAN SELECTION

1b. Number of Plans Selected by Employers – Hometown Health allows Small Employers to select up to two (2) plans for less than five enrolled employers and up to three (3) plans for five or more enrolled employees. There is no restriction of metal levels offered.

☐ HMO	☐ EPO	☐ PPO	☐ Vision
Plan Elected	**Plan Elected**	**Plan Elected**	**Plan Elected**

Hometown Health

COBRA ADMINISTRATOR

IF YOU ARE AN EMPLOYER WHO HAD A TOTAL OF 20 OR MORE EMPLOYEES

(including full-time, part-time, seasonal, per diem, etc.) for at least 50% of the previous calendar year (i.e., 6 months or more), you are required to offer COBRA coverage. This requirement also applies if you offer health benefits through an Association Health Plan, regardless of employee count. Hometown Health is partnered with iSolved to provide basic COBRA administration at no additional cost, included in your health benefits plans—making compliance easier for you.

IF YOUR GROUP QUALIFIES TO OFFER COBRA, PLEASE COMPLETE ALL SECTIONS BELOW:

Legal Name _____

Address _____

City _____ State _____ Zip _____

Federal Employer Identification Number _____

Total Number of Eligible Employees _____

Total Number of Insured Employees _____

Service Start Date _____

Signer Name _____

Signer Email _____

Broker Name _____

Broker Email _____

Once we receive this information, we will send it to iSolved.
iSolved will then send documentation to the Signer's email address via DocuSign.
THE DocuSign MUST BE COMPLETED AND SIGNED
IN ORDER FOR THE GROUP TO BE ESTABLISHED WITH iSolved.

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GROUP ELIGIBILITY AND PAYMENT PROVISIONS

Please return with renewal/new packet.

A Company Name _____

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 *(Please select one)*

- ☐ 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 Employement Begins on Date of Hire

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 =* _____

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 - only applies to employees covered prior to termination with current carrier.

3c. Rehire Employee Policy

☐ **DOES NOT APPLY**

OR

☐ **DOES APPLY**

If Rehired within _____ ☐ Days OR ☐ Months of Termination, then Coverage is Effective 1st of the Month on or following.

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 _____

The Group appoints the following Company / Agency as Producer of Record:

Print Company / Agency _____

Print Producer Name _____

AREA FOR HOMETOWN HEALTH USE ONLY

Renewal Effective Date _____

Date _____ SSR _____ Section Changed _____ Effective Date _____

Hometown Health

NEW GROUP INITIAL ONE-TIME BINDER PAYMENT
eCheck/Credit Card Authorization Form

This form provides authorization to draft Company's initial one-time binder payment for new group premium.

PLEASE FILL OUT THE INFORMATION BELOW

to have an eCheck or Credit Card withdrawal for company's initial one-time binder payment.

Company Name _____

Billing Address _____

City _____ State _____ Zip _____

Email Address _____

BINDER PREMIUM INFORMATION

Initial One-Time Binder Payment Amount $ _____

BANK ACCOUNT TYPE – CHECK ONE ☐ Checking ☐ Savings

Account Holder Name _____

Routing Number _____

Account Number _____

IF PAYING BY CREDIT CARD

Account Holder Name _____

Account Number _____ Exp Date _____

Security Code _____ *(3 TO 4 DIGIT CODE ON BACK OR FRONT OF CARD)*

Authorization Agreement: *By signing below, I confirm that I am an authorized representative and signatory of the above Company and hereby authorize Hometown Health to withdraw the* ***INITIAL ONE-TIME BINDER PAYMENT*** *from Company's bank or credit card account. I understand that this* ***INITIAL ONE-TIME BINDER PAYMENT*** *will be deducted from Company's account within one (1) to two (2) days after notification of Hometown Health's approval of Company's enrollment in a Hometown Health plan.*

Name *(PRINTED)* _____ Company Title _____

Company's Authorized Representative Signature _____ Date _____

FOR INTERNAL USE ONLY

Date funds withdrawn _____ **Initials** _____ **Confirmation/Transaction#** _____ *(ATTACH RECEIPTS)*

AMOUNT **EPO/HMO $** _____ **Invoice#** _____ **PPO $** _____ **Inv#** _____

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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

☐ HMO
Plan Elected

☐ EPO
Plan Elected

☐ PPO
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
EPO Exclusive Provider 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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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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