



SMALL GROUP 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*)



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)



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



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 _____



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



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.



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:	
<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 (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 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	Termination of Coverage = Last day of month which employee ceases to be eligible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> 1st of Month on or following 1 month of eligible employment	Termination of Coverage = Last day of month which employee ceases to be eligible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> 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)



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 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 _____

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 _____



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# _____

G# _____
 M# _____
 L _____
 F, M _____



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

<input type="checkbox"/> HMO Plan Elected	<input type="checkbox"/> EPO Plan Elected	<input type="checkbox"/> 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.

<input type="checkbox"/> Left Company	<input type="checkbox"/> Ineligible
<input type="checkbox"/> Deceased	<input type="checkbox"/> Dissatisfied
<input type="checkbox"/> Moved	<input type="checkbox"/> Other (If other, explain below)

REASON FOR CHANGE

<input type="checkbox"/> New Hire	<input type="checkbox"/> PT/FT
<input type="checkbox"/> Name	<input type="checkbox"/> Reinstatement
<input type="checkbox"/> Annual Election	<input type="checkbox"/> Waive Coverage
<input type="checkbox"/> Rehire	<input type="checkbox"/> Retiree
<input type="checkbox"/> COBRA (18-29-36)	<input type="checkbox"/> Transfer
<input type="checkbox"/> Other (If other, explain below)	
<input type="checkbox"/> Address	

ADD/DELETE DEPENDENT

<input type="checkbox"/> Marriage**	<input type="checkbox"/> Divorce**
<input type="checkbox"/> Birth/Adoption**	<input type="checkbox"/> Other**
<input type="checkbox"/> Loss of Dependent	<input type="checkbox"/> Court Ordered/
<input type="checkbox"/> Status**	Legal Guardianship**
<input type="checkbox"/> Loss of Insurance**	<input type="checkbox"/> Deceased**

**Attach legal documentation as proof of event.

Plan Change From _____ To _____

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
 See Next Page

Date



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) _____



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 _____



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.