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)*

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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

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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:
☐	☐	☐ ______	☐ 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 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 =* ______

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)*

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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 USE ONLY

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

☐ 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

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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