Hometown Health

New Small Group Checklist

Group Name:_____Effective Date:_____

Please be aware that rates are subject to change based on final information and census.

- ☐ **Completed Group Application, including Eligibility Provisions**
- ☐ **Plan Selection(s) and Signed Rate Agreement(s). Group may choose up to three plans.**
  - **Plan 1 _____**
  - **Plan 2 _____**
  - **Plan 3 _____**
- ☐ **If Group has less than 5 employees, Hometown Health requires a copy of the group's most recent filed Wage & Quarterly to confirm qualification as a Small Group.**
- ☐ **If Group has between 35 and 50 employees, Hometown Health requires a copy of the group's most recent filed Wage & Quarterly to confirm qualification as a Small Group.**
- ☐ **Groups may be asked to provide a Business Verification form for members that do not show on the group's Wage & Quarterly report.**
- ☐ **Groups may be randomly pulled by Underwriting for a quality audit at any time.**
- ☐ **Enrollment Applications/Electronic Enrollment Applications or Enrollment File for Electronic Eligibility**
  - **Letter of Attestation for all employees* who are waiving coverage, or who are eligible for and/or participating in COBRA**

    ***For any eligible employee (**"Eligible employee" means a permanent employee who has a regular working week of 30 or more hours *NRS689C.065) need affidavit from Employer Group with employees listed who are waiving coverage*
- ☐ **Estimated 1st month Premium binder check based on the census or actual enrollment.**
  - **Any discrepancy between the binder amount and the final enrollment will be billed or credited on the first premium bill.**

Hometown Health

Enrollment / Change Form

Hometown Health Use Only

G#
M#
L
F,M

Human Resources Only

Employer_____ Group#_____ Effective Date_____
Employee's Weekly Hours_____ Employee's Date of Hire_____ Employer Signature_____

Employee Information

Name (Last)	(First)	(M.I.)	Social Security Number
			___-___-____

Mailing Address (Street or P.O. Box)	City	State	Zip Code	County

Physical Address	City	State	Zip Code	County

Date of Birth	Marital Status	Occupation	Home Phone	Work Phone
____/____/____	Married ❑ Single ❑ Divorced ❑ Widowed ❑		( )____-____	( )____-____

Plan Elected

❑ HMO Plan Elected_____ ❑ PPO Plan Elected_____ ❑ PPO w/HSA* Plan Elected_____ ❑ HMO w/HSA* Plan Elected_____

*Street Address only, no P.O. Boxes

Other Medical Coverage:

Do you or any of your Dependents listed below 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 ❑ Moved ❑ Dissatisfied
❑ Deceased ❑ Ineligible ❑ Other_____

Reason for Change

❑ New Hire
❑ Name
❑ Annual Election
❑ Rehire
❑ Other_____
❑ COBRA (18-29-36)
❑ PT/FT
❑ Reinstatement
❑ Waive Coverage
❑ Retiree
❑ Transfer
❑ Address

Plan Change: From:_____To:_____

Add/Delete Dependent

*❑ Marriage *❑Divorce
*❑Birth/Adoption *❑Other
*❑Loss of Dependent Status *❑Court Ordered/Legal Guardianship
*❑ Loss of Insurance *❑Deceased

* Attach legal documentation as proof of event.

Member Information – Complete with new or change information

Action	*(Last) (First) (M.I.)	Social Security Number	Birth Date Mo./Day/Yr.	Sex M/F	Reside with Emp.? Y/N	**PRIMARY CARE PHYSICIAN (if required)
Add ❑ Change ❑ Delete ❑	Employee:				-	
	Email Address:					
Add ❑ Change ❑ Delete ❑	Spouse					
	Email Address					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					
Add ❑ Change ❑ Delete ❑	Dependent Child (Relationship)					
	This Shaded Space For Hometown Health Use Only					

** It is member's responsibility to verify physician availability in their area.

Revised Mar. 2015

ACKNOWLEDGEMENT OF TERMS Employee Signature X_____Date_____
(SEE REVERSE SIDE)

Hometown Health

10315 Profesional Circle~ Reno, Nevada 89521 (775) 982-3100 www.hometownhealth.com

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):

   _____

   1a. Federal Tax ID #: _____ 1b. IRS Section 125: ☐YES ☐ NO

2. **ADDRESS:**

   _____

   Location Address Street City State Zip Code

   _____

   Mailing Address (If different) Street or PO Box City State Zip Code

   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):

   _____

   Name Street City State Zip Code

   _____

   4a. Mailing Address (If different) 4b. Telephone # 4c. Fax #

5. **BUSINESS INDUSTRY OR NATURE OF BUSINESS:**

   _____

6. **NAICS CODE:** (If available): _____ 6a**. MEMBER OF BANN:** ☐YES ☐ NO

7. **COMPANY TYPE**: ☐ Corporation ☐ LLC ☐ Non-Profit ☐ Partnership ☐ Political Subdivision ☐ S –Corp.
   ☐ Sole Proprietorship ☐ Union ☐ Other: _____

8. **YEAR BUSINESS ESTABLISHED:** _____

   8a. #Employees (FT & PT): _____ 8b. #Employees Eligible To Enroll: _____ 8c. #Employees Waiving Enrollment: _____

   8d. Please check appropriate box below to indicate your organization's size*: *"Mandatory Insurer Reporting Law-Section 111 of Public Law 110-173"

   - ☐ Less than 20 full- or part-time employees*
   - ☐ 20 to 99 full- or part-time employees*
   - ☐ 100 or more full- or part-time employees*

   * 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 Example- Dental and/or Vision

   9a. If Yes - Coverage Type: _____Carrier Name: _____

   Coverage Type: _____Carrier Name: _____

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: _____

Area for Hometown Health use:

EFFECTIVE DATE:_____ **PARENT CODE:** _____

GROUP INFORMATION

A. COMPANY INFORMATION:

1a. COMPANY NAME _____

B. COMPANY BENEFIT ADMINISTRATOR(S):
1b. CORPORATE CONTACT:

_____
Name Title

_____
Address City State Zip Code

Telephone #: _____, Ext#____ Fax #: _____ Email:_____

1a. Receives Contract / Renewal Notices ☐ 1b. Receives Hometown Health Employer Newsletter ☐

2b. LOCAL CONTACT (If same as Corporate Contact, leave blank)**:**

_____
Name Title

_____
Address City State Zip Code

Telephone #: _____, Ext#____ Fax #: _____ Email:_____

2a. Receives Contract / Renewal Notices ☐ 2b. Received Hometown Health Employer Newsletter ☐

3b. PREMIUM BILLING CONTACT (If different than Contacts listed above)**:**

_____
Name Title

_____
Address City State Zip Code

Telephone #: _____, ext#____ Fax #: _____ Email:_____

4b. OTHER COMPANY CONTACTS (If applicable)**:**

_____
Name Title

Telephone #: _____, ext#____ Fax #: _____ Email:_____

GROUP ELIGIBILITY AND PAYMENT PROVISIONS

Please return with renewal/new packet

A: COMPANY NAME: _____ Group Size: _____

Check category in each Provisions Sections: "B" Eligibility Status, "C" Commencement of Coverage

B: ELIGIBILITY STATUS (check all categories applicable):

SALARIED	HOURLY	OTHER (Please list)	B1. ELIGIBLE EMPLOYEES:
☐	☐	☐ _____	☐ Active Employees ☐ Retirees:
☐	☐	☐ _____	☐ Permanent Full Time employees scheduled to work at least hours per week. *"Eligible employee means a permanent employee who has a regular working week of 30 or more hours.../NRS689C.065
☐	☐	☐ _____	☐ Other: (Attach Explanation)
☐	☐	☐ _____	☐ Leave of Absence:

B2. DEPENDENT POLICY:

- ☐ Employee Only (available for Employers with fewer than 50 fulltime 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)	C1 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 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 =

C2. 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 this section is not addressed, policy will default to Newly Eligible Employee Provision

C3. PART TIME TO FULL TIME POLICY

(Only applies to large groups)

☐ Does Not Apply

Minimum # 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.

C4. REHIRE EMPLOYEE POLICY

☐ Does Not Apply

If rehired within ____ ☐ Days or ☐ Months of termination then 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)

PAYMENT PROVISIONS

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.

Dated this _____day of _____, year_____

_____ _____

(Print Name and Title of Company Representative) (Signature of Company Representative)

Primary Contact and email: _____

Secondary Contact and email: _____

Notes:

This area for internal use only-

Renewal Effective Date _____

Date _____ **SSR** _____ **Section Chg'd**_____ **Eff. 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.

1. PRODUCER OF RECORD:

Company / Agency: _____

Producer Name: _____

_____
Address City State Zip Code

Telephone #: _____, Ext#____ Fax #: _____ Email:_____

IRS Tax ID #: _____

2. SECOND PRODUCER OF RECORD (If applicable):

Company / Agency: _____

Producer Name: _____

_____
Address City State Zip Code

Telephone #: _____, Ext#____ Fax #: _____ Email:_____

IRS Tax ID #: _____

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 #

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.

Dated at _____ this _____ day of _____, year _____

_____ _____
(Print Name and Title of Producer) (Signature of 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:

   Company / Agency (PRINT): _____

   Producer Name (PRINT): _____

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.

Dated at _____ this _____ day of _____, year _____

_____ _____

(Print Name and Title of Company Representative) (Signature of Company Representative)

Acknowledgement 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
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):

Hometown Health

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 REVERSE SIDE"

EMPLOYER INFORMATION		
Name of Employer:		
Address:		
City:	State:	Zip:
Telephone:		

APPLICANT / EMPLOYEE INFORMATION		
Last Name:	First Name:	MI:
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 BY 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.

REV: 09/2008