Health Insurance Application Checklist

Business Name: _____ Effective Date: _____

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.

All applicants

- ☐ Completed application and plan selections
- ☐ Current state business license number
- ☐ Completed Business Attestation Form
- ☐ Enrollment application, electronic enrollment application, or enrollment file for electronic eligibility
- ☐ Estimated 1st month premium binder check
    - 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 Wage & Quarterly
    - Businesses in operation less than three months may submit a Business Verification Form and two weeks of payroll receipts in lieu of Wage & Quarterly.
- ☐ Business Verification Form and two weeks of payroll receipts for employees that do not appear on the group's Wage & Quarterly
- ☐ Letter of Attestation 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 (including sole proprietors) that do not appear on the Wage & Quarterly *(provide at least one item from the list below)*

- ☐ Form 1040 Schedule C *(if applicable)*
- ☐ US Return of Partnership Income Form 1065 (Schedule K-1) *(if applicable)*
- ☐ US Return of Shareholder Income Form 1120S (Schedule K-1) *(if applicable)*

Builders Association of Northern Nevada (BANN) Builders/Subcontractors

- ☐ Current contractor license

Attestation Form
For
Sole Proprietor or Business where the Owner is the Sole Employee
Partnerships with No Employees

Business Organization Information:

Name of Organization: _____

State Business License #: _____

Primary Business Activity: _____

Address: _____

City:_____ State:_____ Zip: _____

Contact Information for Business Organization

Name: _____

Title: _____

Phone Number: _____Fax: _____

Check one below:

☐ **Sole Proprietor or Business where the Owner is the Sole Employee**. I hereby attest that: (i) I am the owner and operator of the above described business organization; (ii) I work a minimum of thirty (30) hours per week for this business organization; (iii) I (and my eligible dependents) am the only person eligible for health coverage through the above described business organization.

☐ **Partnership**. I hereby attest that: (i) I am one of the owners of the above described business organization and have the authority to enter into an agreement to purchase health insurance coverage on behalf of all of the partners of this business organization; (ii) the above business organization does not offer health insurance coverage to any of the partners through another company; (iii) the above business organization does not have any "W-2" employees; (iv) only the partners that work a minimum of thirty (30) hours per week for this business (and their eligible dependents) will seek health coverage through the organization.

☐ **None of the Above**. If the above does not describe you, check here; no signature is needed.

I agree to provide upon request appropriate tax forms to Hometown Health to validate the eligibility status. Before application will be approved, the applicant must execute this Attestation Form and provide the tax information and related documents indicated on the attached checklist. Hometown Health reserves the right to modify these documentation and eligibility requirements in the future. I agree to promptly advise Hometown Health in the event that any of the statements made in this Attestation are no longer accurate. The undersigned certifies that, to the best of his or her knowledge and belief, and under penalty of perjury, the information listed above is true and complete.

_____ _____

Signature of Applicant Date

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.

Name of Employer Group: _____

Business Member: _____

Primary Business Location: _____

Name of Business Entity	Employer Federal Tax ID Number (FEIN)	% Ownership	# 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

Application and Adoption Agreement for Association Health Plan Employer Group Enrollment

This APPLICATION AND ADOPTION AGREEMENT FOR ASSOCIATION HEALTH PLAN EMPLOYER GROUP ENROLLMENT ("Agreement") in the association health plan program provided by Hometown Health Providers Insurance Company, Inc. and Hometown Health Plan, Inc. (collectively referred to as "Hometown Health") and Builders Association of Northern Nevada ("Association") is hereby submitted by the following Employer Group:

1. FULL LEGAL NAME OF EMPLOYER GROUP

_____

2. LOCATION ADDRESS

_____

Street City State Zip Code

3. REQUESTED EFFECTIVE DATE (first of a month) ASSOCIATION GROUP ID

_____ _____

All initial and renewal terms will be 12 months. All days begin and end at 12:00 midnight.

I certify that:

1. This is a bona-fide business establishment that has 50 or fewer full time equivalent employees and meets and will continue to meet all Association participation requirements.
2. I understand the Association Health Plan Participation Requirements and that those requirements must be met and maintained for the group to be and remain eligible for coverage.
3. I wish to enroll in and agree to the terms of the Policy and this Agreement, the Association's Group Subscription Agreement, the applicable Evidence of Coverage and Schedule of Benefits and the Association Health Plan Participation Requirements.
4. I understand and agree to abide by the eligibility rules applicable to employee and dependent enrollment as well as payment rules as provided in my approved Plan, this Agreement and the Policy and that this Agreement can only be revised at renewal in writing.
5. 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.
6. I herewith tender $_____and, in consideration of approval of the Agreement, promise to pay any balance necessary to constitute the full initial payment herein identified. It is understood that Association and/or Hometown Health have the right to accept or reject this Agreement. Coverage will not commence until the Agreement has been accepted.
7. To the best of my knowledge and belief, the information provided in this Application is true and is the basis for issuance of coverage.

_____

Print name and title of **Employer Group** representative

_____ _____

Signature of **Employer Group** representative Date

_____

Producer Title, Name & Agency

_____ _____

Producer Signature Date

For Hometown Health use only:
Approved effective date: _____
Parent code: _____

4. TAX INFORMATION:
4a. Federal Tax ID #: _____ 4b. IRS Section 125: ☐ YES ☐ NO

4c. Year Business Established _____

5. MAILING ADDRESS (if different from the location listed in item 2 above):

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

6. NAME & TITLE OF OWNER, GENERAL MANAGER OR CEO:

_____
Name Title

Telephone: _____ Fax: _____ Email: _____

7. COMPANY BILLING NAME AND ADDRESS (If different from legal name in item 1 above):

_____
Name

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

8. BUSINESS INDUSTRY OR NATURE OF BUSINESS:

_____ _____
Description NAICS Code

9. COMPANY TYPE: ☐ Corporation ☐ LLC ☐ Non-profit ☐ Partnership ☐ S–Corp.
☐ Political Subdivision ☐ Union ☐ Sole Proprietor ☐ Other: _____

10. COMPANY SIZE:
10a. #Employees (FT & PT): _____ 10b. #Employees Eligible To Enroll: _____ 10c. #Employees Waiving Enrollment: _____
10d. 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*
* If organization represents multiple employer groups, please count employees in other groups also.

11. EMPLOYEES BY COUNTY
Enter the number of employees eligible to enroll that live in the following areas (total should equal 10b above):
1 – Clark & Nye: _____ 2 – Washoe: _____ 3 – Carson, Douglas, Storey, Lyon & Eastern CA: _____
4 – All other Nevada: _____ 5 – All other out of state: _____

12. PLANS (select up to 3 medical plans; employers with less than 10 enrolled employees may select 2 medical plans):
Medical Plan 1: _____ Dental Plan: _____
Medical Plan 2: _____ Vision Plan: _____
Medical Plan 3: _____ Other: _____

13. OTHER COVERAGE:
Does your company offer other insurance options (i.e. dental/vision) not associated with Hometown Health? ☐ YES ☐ NO
13a. If Yes:
Coverage Type: _____ Carrier Name: _____
Coverage Type: _____ Carrier Name: _____

14. EMPLOYER CONTRIBUTION:
Enter the percentage (%) or dollar ($) amount (minimum is 50% of total funding requirement):

Hourly Employees	Salaried Employees	Other (Please specify):
Employees: _____	Employees: _____	Employees: _____
Dependents: _____	Dependents: _____	Dependents: _____

15. CORPORATE CONTACT:

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

16. LOCAL CONTACT (If same as corporate contact, leave blank):

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

17. PREMIUM BILLING CONTACT (If same as corporate or local contact, leave blank):

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

18. OTHER CONTACT (If applicable):

Name _____ Title _____

Telephone: _____ Fax: _____ Email: _____

19. EMPLOYEE ELIGIBILITY:
All employees who meet the waiting period requirement and who work at least 30 hours per week are eligible. Additionally, those employees who are on Family Medical Leave Act (FMLA) leave are eligible.

20. DEPENDENT ELIGIBILITY:
- ☐ Employee Only
- ☐ Employees and dependent children
- ☐ Employees, spouse and dependent children
- ☐ Employees, spouses, domestic partners and dependent children

21. WAITING PERIOD

Eligible employment begins on:
- ☐ On the date of hire (default).
- ☐ Following a reasonable and bona fide employment-based orientation period of ____ days (not to exceed 30 days).

Eligible employment also begins when a part time employee transitions to full time.

Salaried	Hourly	Other (Please list)	Once eligible employment begins as described above, employee *coverage* begins:
☐	☐	☐ :	☐ 1st of the month on or following date of eligible employment
☐	☐	☐ :	☐ 1st of the month on or following ____ day(s) of eligible employment (60 days max)
☐	☐	☐ :	☐ 1st of the month on or following 1 month of eligible employment

22. REHIRE POLICY:

This section only applies to employees that were covered under the employee health plan on the date of termination of the immediately previous employment period.
- ☐ Does not apply (default – rehire policy will default to newly eligible employee provisions)
- ☐ If rehired within ____ days (365 days max) then coverage effective on the 1st of the month following rehire.
- ☐ If rehired within ____ months (12 months max) then coverage effective on the 1st of the month following rehire.

23. COVERAGE BEGIN AND END:

Emlpoyee coverage always begins on the first of the month. Dependent coverage always begins on the first of the month, except in the case of birth, adoption or placement for adoption, in which case coverage begins on the date of the event and in the case of loss of other coverage in which case coverage begins on the day after loss of coverage. Coverage always ends on the last day of the month in which the employee ceases to be eligible, except in the case of death.

24. PAYMENT PROVISIONS:

If coverage begins on: The 1st through the 15th of the month – FULL PREMIUM and HEATLH PLAN FUNDING DUE
The 16th through the end of the month – NO PREMIUM or HEATLH PLAN FUNDING DUE

If coverage ends on: The 1st through the 15th of the month – NO PREMIUM or HEATLH PLAN FUNDING DUE
The 16th through the end of the month – FULL PREMIUM and HEATLH PLAN FUNDING DUE

25. PRODUCER OF RECORD (New producers contract Sales & Marketing at (775)982-3100):

Company/Agency

Producer Name

26. SECOND PRODUCER OF RECORD (if applicable; new producers contract Sales & Marketing at (775)982-310):

Company/Agency

Producer Name

☐ Split commission. Second producer of record will receive _____% (1-99%) of the commissions applicable to this employer group.

Application and Adoption Agreement for Association Health Plan Employer Group Enrollment

This APPLICATION AND ADOPTION AGREEMENT FOR ASSOCIATION HEALTH PLAN EMPLOYER GROUP ENROLLMENT ("Agreement") in the association health plan program provided by Hometown Health Providers Insurance Company, Inc. and Hometown Health Plan, Inc. (collectively referred to as "Hometown Health") and Better Business Bureau (BBB) Northern Nevada and Utah ("Association") is hereby submitted by the following Employer Group:

1. FULL LEGAL NAME OF EMPLOYER GROUP

_____

2. LOCATION ADDRESS

_____

Street City State Zip Code

3. REQUESTED EFFECTIVE DATE (first of a month) ASSOCIATION GROUP ID

_____ _____

All initial and renewal terms will be 12 months. All days begin and end at 12:00 midnight.

I certify that:

1. This is a bona-fide business establishment that has 50 or fewer full time equivalent employees and meets and will continue to meet all Association participation requirements.
2. I understand the Association Health Plan Participation Requirements and that those requirements must be met and maintained for the group to be and remain eligible for coverage.
3. I wish to enroll in and agree to the terms of the Policy and this Agreement, the Association's Group Subscription Agreement, the applicable Evidence of Coverage and Schedule of Benefits and the Association Health Plan Participation Requirements.
4. I understand and agree to abide by the eligibility rules applicable to employee and dependent enrollment as well as payment rules as provided in my approved Plan, this Agreement and the Policy and that this Agreement can only be revised at renewal in writing.
5. 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.
6. I herewith tender $_____and, in consideration of approval of the Agreement, promise to pay any balance necessary to constitute the full initial payment herein identified. It is understood that Association and/or Hometown Health have the right to accept or reject this Agreement. Coverage will not commence until the Agreement has been accepted.
7. To the best of my knowledge and belief, the information provided in this Application is true and is the basis for issuance of coverage.

_____

Print name and title of **Employer Group** representative

_____ _____

Signature of **Employer Group** representative Date

_____

Producer Title, Name & Agency

_____ _____

Producer Signature Date

For Hometown Health use only:
Approved effective date: _____
Parent code: _____

Application and Adoption Agreement
for
Association Health Plan Employer Group Enrollment

4. TAX INFORMATION:
4a. Federal Tax ID #: _____ 4b. IRS Section 125: ☐ YES ☐ NO

4c. Year Business Established _____

5. MAILING ADDRESS (if different from the location listed in item 2 above):

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

6. NAME & TITLE OF OWNER, GENERAL MANAGER OR CEO:

_____
Name Title

Telephone: _____ Fax: _____ Email: _____

7. COMPANY BILLING NAME AND ADDRESS (If different from legal name in item 1 above):

_____
Name

_____
Street or PO Box City State Zip Code

Telephone: _____ Fax: _____ Email: _____

8. BUSINESS INDUSTRY OR NATURE OF BUSINESS:

_____ _____
Description NAICS Code

9. COMPANY TYPE: ☐ Corporation ☐ LLC ☐ Non-profit ☐ Partnership ☐ S–Corp.
☐ Political Subdivision ☐ Union ☐ Sole Proprietor ☐ Other: _____

10. COMPANY SIZE:
10a. #Employees (FT & PT): _____ 10b. #Employees Eligible To Enroll: _____ 10c. #Employees Waiving Enrollment: _____
10d. 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*
* If organization represents multiple employer groups, please count employees in other groups also.

11. EMPLOYEES BY COUNTY
Enter the number of employees eligible to enroll that live in the following areas (total should equal 10b above):
1 – Clark & Nye: _____ 2 – Washoe: _____ 3 – Carson, Douglas, Storey, Lyon & Eastern CA: _____
4 – All other Nevada: _____ 5 – All other out of state: _____

12. PLANS (select up to 3 medical plans; employers with less than 10 enrolled employees may select 2 medical plans):
Medical Plan 1: _____ Dental Plan: _____
Medical Plan 2: _____ Vision Plan: _____
Medical Plan 3: _____ Other: _____

13. OTHER COVERAGE:
Does your company offer other insurance options (i.e. dental/vision) not associated with Hometown Health? ☐ YES ☐ NO
13a. If Yes:
Coverage Type: _____ Carrier Name: _____
Coverage Type: _____ Carrier Name: _____

14. EMPLOYER CONTRIBUTION:
Enter the percentage (%) or dollar ($) amount (minimum is 50% of total funding requirement):

Hourly Employees	Salaried Employees	Other (Please specify):
Employees: _____	Employees: _____	Employees: _____
Dependents: _____	Dependents: _____	Dependents: _____

15. CORPORATE CONTACT:

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

16. LOCAL CONTACT (If same as corporate contact, leave blank):

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

Receives Contract / Renewal Notices ☐ Receives Hometown Health Employer Newsletter ☐

17. PREMIUM BILLING CONTACT (If same as corporate or local contact, leave blank):

Name _____ Title _____

Street or PO Box _____ City _____ State _____ Zip Code _____

Telephone: _____ Fax: _____ Email: _____

18. OTHER CONTACT (If applicable):

Name _____ Title _____

Telephone: _____ Fax: _____ Email: _____

19. EMPLOYEE ELIGIBILITY:
All employees who meet the waiting period requirement and who work at least 30 hours per week are eligible. Additionally, those employees who are on Family Medical Leave Act (FMLA) leave are eligible.

20. DEPENDENT ELIGIBILITY:
- ☐ Employee Only
- ☐ Employees and dependent children
- ☐ Employees, spouse and dependent children
- ☐ Employees, spouses, domestic partners and dependent children

21. WAITING PERIOD

Eligible employment begins on:
- ☐ On the date of hire (default).
- ☐ Following a reasonable and bona fide employment-based orientation period of ____ days (not to exceed 30 days).

Eligible employment also begins when a part time employee transitions to full time.

Salaried	Hourly	Other (Please list)	Once eligible employment begins as described above, employee *coverage* begins:
☐	☐	☐ :	☐ 1st of the month on or following date of eligible employment
☐	☐	☐ :	☐ 1st of the month on or following ____ day(s) of eligible employment (60 days max)
☐	☐	☐ :	☐ 1st of the month on or following 1 month of eligible employment

22. REHIRE POLICY:

This section only applies to employees that were covered under the employee health plan on the date of termination of the immediately previous employment period.
- ☐ Does not apply (default – rehire policy will default to newly eligible employee provisions)
- ☐ If rehired within ____ days (365 days max) then coverage effective on the 1st of the month following rehire.
- ☐ If rehired within ____ months (12 months max) then coverage effective on the 1st of the month following rehire.

23. COVERAGE BEGIN AND END:

Emlpoyee coverage always begins on the first of the month. Dependent coverage always begins on the first of the month, except in the case of birth, adoption or placement for adoption, in which case coverage begins on the date of the event and in the case of loss of other coverage in which case coverage begins on the day after loss of coverage. Coverage always ends on the last day of the month in which the employee ceases to be eligible, except in the case of death.

24. PAYMENT PROVISIONS:

If coverage begins on: The 1st through the 15th of the month – FULL PREMIUM and HEATLH PLAN FUNDING DUE
The 16th through the end of the month – NO PREMIUM or HEATLH PLAN FUNDING DUE

If coverage ends on: The 1st through the 15th of the month – NO PREMIUM or HEATLH PLAN FUNDING DUE
The 16th through the end of the month – FULL PREMIUM and HEATLH PLAN FUNDING DUE

25. PRODUCER OF RECORD (New producers contract Sales & Marketing at (775)982-3100):

Company/Agency

Producer Name

26. SECOND PRODUCER OF RECORD (if applicable; new producers contract Sales & Marketing at (775)982-310):

Company/Agency

Producer Name

☐ Split commission. Second producer of record will receive _____% (1-99%) of the commissions applicable to this employer group.

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)

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