

**Application and Adoption Agreement
for
Association Health Plan Sole Proprietor Enrollment**

This APPLICATION AND ADOPTION AGREEMENT FOR ASSOCIATION HEALTH PLAN SOLE PROPRIETOR 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 the Nevada Realtors (“Association”) is hereby submitted by the following Employer Group:

1. FULL LEGAL NAME OF SOLE PROPRIETOR BUSINESS OR SOLE PROPRIETOR

2. LOCATION ADDRESS

Street	City	State	Zip Code
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3. REQUESTED EFFECTIVE DATE (first of a month) STATE BUSINESS LICENSE NUMBER

_____ All initial and renewal terms will end at 12:00 midnight on December 31.

I certify that:

1. This is a bona-fide business establishment licensed as a sole proprietor 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 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 agree to abide by the eligibility rules applicable to employee and dependent enrollment as well as timely eligibility and termination notice and 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 **Sole Proprietor**

_____ Signature of **Sole Proprietor**

_____ Date

_____ **Producer** Title, Name & Agency

_____ **Producer** Signature

_____ Date

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

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4. TAX INFORMATION:

4a. Federal Tax ID # (or SSN): _____ 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 SOLE PROPRIETOR:

Name _____ Title _____

Telephone: _____ Fax: _____ Email: _____

7. 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:

<u>Offices of Real Estate Agents and Brokers</u>	<u>531210</u>
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): 1 10b. #Employees Eligible To Enroll: 1 10c. #Employees Waiving Enrollment: 0

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 a "1" in the appropriate county group below:

1 – Nye: _____ 2 – Washoe: _____ 3 – Carson, Douglas, Storey, Lyon & Eastern CA: _____
4 – All other Nevada: _____

12. PLANS (Which medical plan have you selected? Write your selection next to Medical Plan 1)

Medical Plan 1: _____	Dental Plan: <u>N/A</u>
Medical Plan 2: <u>N/A</u>	Vision Plan: <u>N/A</u>
Medical Plan 3: <u>N/A</u>	Other: <u>N/A</u>

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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: N/A Carrier Name: N/A
Coverage Type: N/A Carrier Name: N/A

14. EMPLOYER CONTRIBUTION:

Enter the percentage (%) or dollar (\$) amount (minimum is 50% of total funding requirement):

Hourly Employees	Salaried Employees	Other (Please specify):
Employees: <u>N/A</u>	Employees: <u>100%</u>	Employees: _____
Dependents: <u>N/A</u>	Dependents: <u>100%</u>	Dependents: _____

15. CORPORATE CONTACT:

Name _____		Title _____	
Street or PO Box _____		City _____	State _____ Zip Code _____
Telephone: _____	Fax: _____	Email: _____	
Receives Contract / Renewal Notices <input type="checkbox"/>		Receives Hometown Health Employer Newsletter <input type="checkbox"/>	

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 <input type="checkbox"/>		Receives Hometown Health Employer Newsletter <input type="checkbox"/>	

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:

You must be a member in good standing of Nevada Realtors.

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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:
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> :	<input checked="" type="checkbox"/> 1 st of the month on or following date of eligible employment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/> 1 st of the month on or following ____ day(s) of eligible employment (60 days max)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/> 1 st 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:

Employee 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 (in the case of birth, adoption, death or loss of coverage):

If coverage begins on: The 1st through the 15th of the month – FULL PREMIUM and HEALTH PLAN FUNDING DUE
 The 16th through the end of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE
 If coverage ends on: The 1st through the 15th of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE
 The 16th through the end of the month – FULL PREMIUM and HEALTH 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) 982-3100):

Company/Agency

Producer Name

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