

4. PLANS (select 1 medical plan if only 1 employee enrolls; up to 2 medical plans for 2 – 4 enrolled employees; up to 3 medical plans for 5+ enrolled employees):

PPO Plan Options

- 21 AP PPO 00-CO 1000 A D0000X2
- 21 AP PPO 10-CO 2000 A D0500X2
- 21 AP PPO 15-CO 2500 A D1000X2
- 21 AP PPO 20-CO 3000 A D2000X2
- 21 AP PPO 30-CO 3500 A D3000X2
- 21 AP PPO 30-CO 3500 A D4000X2
- 21 AP PPO 35-70 CINS P D4500X2
- 21 AP PPO 40-70 CINS P D5500X2
- 21 AP PPO 10-70 CINS U D1400X2 HSA
- 21 AP PPO 10-70 CINS E D3700X2 HSA
- 21 AP PPO 45-NA 0000 P D8550X2
- 21 AP PPO 45-00 CINS E D3500X2 HSA
- 21 AP PPO 00-NA 0000 E D7000X2 HSA
- 21 AP PPO 00-NA 0000 P D8550X2

HMO Plan Options

- 21 AP HMO 00-CO 1000 A D0000X2
- 21 AP HMO 10-CO 2000 A D0500X2
- 21 AP HMO 15-CO 2500 A D1000X2
- 21 AP HMO 20-CO 3000 A D2000X2
- 21 AP HMO 30-CO 3500 A D3000X2
- 21 AP HMO 30-CO 3500 A D4000X2
- 21 AP HMO 35-70 CINS P D4500X2
- 21 AP HMO 40-70 CINS P D5500X2
- 21 AP HMO 10-70 CINS U D1400X2 HSA
- 21 AP HMO 10-70 CINS E D3700X2 HSA
- 21 AP HMO 45-NA 0000 P D8550X2
- 21 AP HMO 45-00 CINS E D3500X2 HSA
- 21 AP HMO 00-NA 0000 E D7000X2 HSA
- 21 AP HMO 00-NA 0000 P D8550X2

Dental Plan: _____

Vision Plan: _____

If you are renewing coverage and have no changes to any information on the following pages, stop here.

If you are renewing coverage, but information requested on the following pages has changed, please fill out those sections that have changed.

If you are applying for coverage under this Association for the first time, please complete the remainder of the application in its entirety.



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5. TAX INFORMATION:

4a. Federal Tax ID #: _____ 4b. IRS Section 125: YES NO
 4c. Year Business Established _____

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

Street or PO Box _____ City _____ State _____ Zip Code _____
 Telephone: _____ Fax: _____ Email: _____

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

Name _____ Title _____
 Telephone: _____ Fax: _____ Email: _____

8. 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: _____

9. BUSINESS INDUSTRY OR NATURE OF BUSINESS:

Description _____ NAICS Code _____

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

11. 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.

12. 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, and Lyon: _____
 4 – All other Nevada: _____ 5 – All other out of state: _____

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: _____



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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 <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:

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



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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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> :	<input 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:

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) 982-310):

Company/Agency

Producer Name

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