



**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 the Carson City Chamber of Commerce (“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)      STATE BUSINESS LICENSE NUMBER

\_\_\_\_\_

All initial and renewal terms will be 12 months, except for sole proprietors, which will end on December 31. All days begin and end at 12:00 midnight.

I certify that:

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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

<p>For Hometown Health use only:</p> <p>Approved effective date: _____</p> <p>Parent code: _____</p>
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**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, and Lyon: \_\_\_\_\_  
 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: \_\_\_\_\_



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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: \_\_\_\_\_ 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 <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.



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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 <i>coverage</i> begins:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/> 1 <sup>st</sup> of the month on or following date of eligible employment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/> 1 <sup>st</sup> 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 <sup>st</sup> 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 1<sup>st</sup> of the month following rehire.
- If rehired within \_\_\_\_ months (12 months max) then coverage effective on the 1<sup>st</sup> 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 1<sup>st</sup> through the 15<sup>th</sup> of the month – FULL PREMIUM and HEALTH PLAN FUNDING DUE  
   The 16<sup>th</sup> through the end of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE  
 If coverage ends on:     The 1<sup>st</sup> through the 15<sup>th</sup> of the month – NO PREMIUM or HEALTH PLAN FUNDING DUE  
   The 16<sup>th</sup> 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.