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) 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:

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 understand this Policy doesn't include Pediatric Dental coverage. You affirm that coverage was or will be obtained from a policy issued by Hometown Health or another insurance company.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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: _____

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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: _____

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:

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.