Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

Nevada Association Group Health Plan Application

Because the information provided herein initiates the Health Plan of Nevada, Inc. (HPN), and/or Sierra Health and Life Insurance Group, Inc. (SHL) procedures that produce your billing statement, it is important that you complete this information accurately and return it promptly. Please type or print neatly with black ink. All fields of this Attachment A must be completed.

SECTION 1: Group Profile

☐ Submit a new application ☐ Request change(s) on application for Group # ____________	**Requested Effective Date** (mm/dd/yyyy)

Group Legal Name **DBA/Doing Business As (if applicable)**	**Association Name**	**# Years in Business**

Street Address (PO Box not accepted)	**City**	**State**	**Zip Code**
Billing Address (if different from above)	**City**	**State**	**Zip Code**
Mailing Address (if different from above)	**City**	**State**	**Zip Code**

Phone Number (xxx-xxx-xxxx)	**Federal Tax ID Number**	**SIC No.**	**Nature of Business**

Group Officer Name (Signature in Section 11 must match)	**Group Officer Title**
Group Officer E-mail Address	**Group Officer Phone Number** (xxx-xxx-xxxx)
Enrollment Contact Name (if different from Group Contact)	**Enrollment Contact E-mail Address**
Billing Contact Name (if different from Group Contact)	**Billing Contact E-mail Address** (for electronic billing)

Group Organization Type (select one of the following)

☐ Corporation ☐ Partnership ☐ Limited Liability Corporation (LLC)
☐ Sub-Chapter S Corporation ☐ Non Profit ☐ Limited Liability Partnership (LLP) ☐ Other ____________

Is your group a Professional Employer Organization (PEO) or other such entity that is a co-employer with your client(s) or client-site employee(s)?
☐ Yes ☐ No

If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that Health Plan of Nevada/Sierra Health and Life will not cover the co-employees under this group policy.

Subject to ERISA Regulation? ☐ Yes ☐ No

Are there any other Divisions, Subsidiaries or Affiliates that are part of the Group's business? ☐ Yes (If yes, complete the information below) ☐ No

Name	Tax ID	Physical Address	Applying for Coverage with HPN/SHL	% ownership
			☐ Yes ☐ No	
			☐ Yes ☐ No	

☐ *see attached list*

A copy of the Quarterly Wage and Tax Statement must be provided for each to be included for coverage.
If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.

SECTION 2: Employer/Employee Contribution(s)/Participation

Description of Eligible Employees:

A. Those persons that are bona fide employees of the Group; and
B. Meet the following criteria:

- Be employed full-time by an employer who is a member in good standing with the Association,
- Be in an active employment status,
- Work at least the minimum number of hours per week indicated by the Administrative Services Agreement (ASA),
- Meet the applicable waiting period indicated by the employer in its Group Application,
- Enroll during an enrollment period,
- Work for an employer that meets the Minimum Employer Contribution Percentage for the applicable coverage as set forth in this Group Application, is a member in good standing with the AHP and;
- Live and work in the enrollment area defined in the ASA.

A. **COBRA**: All Association Health Plan Groups are subject to Federal Cobra.

B. Does your Group offer Workers' Compensation? ☐ Yes ☐ No

Participation					Contribution			
** Eligible Employees (including employed owners/officers) work at least the minimum number of hours indicated in the ASA, not including those working on a temporary or substitute basis*		Product Type	# Employees Enrolling	# Employees currently waiving Group coverage		Minimum Employer Contribution	Employer %	Employer for Dependent %
# of Eligible Employees*		Medical			Medical	50%		
# of Ineligible Employees		Dental			Dental			
Total # of Employees		Vision			Vision			
Number of Employees currently in the required probationary/waiting period?		Number of hours per week to be eligible?						
Number of Employees currently on COBRA?								

SECTION 3: Employee Eligibility

Will all current enrolled Eligible Employees be covered on the Effective Date of this Plan	☐ Yes	☐ No
If no, will they have the same Waiting Period as future Eligible Employees?	☐ Yes	☐ No
Will the Group waive the Group Waiting Period?	☐ Initial Only	☐ No
Do you have an orientation period?	☐ Yes	☐ No
Will eligibility documentation be waived?	☐ Initial	☐ No

SECTION 4: Benefit Class Eligibility

Probationary / Waiting Period policy for future Eligible Employees		
Specify class name below	Select either Category A or B for your group. Then specify within the chosen category for each class of employees.	
	Category A Date of Hire	*Category B First of Month Following*
All Eligible Employees	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Date of Hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days
Class 1:	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Following date of hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days
Class 2:	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Following date of hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days
Class 3:	☐ No Wait ☐ 30 days ☐ 60 days ☐ 90 days	☐ Following date of hire ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days

If there are special provisions, please list below: A: Leave of Absence |B: Part Time to Full Time policy |C: Transfer Policy | D: Rehire Policy | E: Promotion Policy F: Reinstate Policy |G: Qualifying Event Policy | K: Other		
Provision Code	Class	Description
Leave of Absence (A)	All Classes (excluding Cobra)	☐ Last Day worked (following the last day worked for the minimum hours required to be eligible) ☐ 3 Months (following the last day worked for the minimum hours required to be eligible) ☐ Other:________________________________ ☐ As stated in group handbook (see attached) ☐ No, we do not offer medical coverage during a leave of absence
☐ see attached list for additional provisions		

SECTION 5: Health Benefit Selection (available to all benefit classes)

Health Plan of Nevada/Sierra Health and Life

☐ HMO ☐ HSA ☐ POS ☐ PPO	Medical 1	Prescription (Rx) 1
☐ HMO ☐ HSA ☐ POS ☐ PPO	Medical 2	Prescription (Rx) 2
☐ HMO ☐ HSA ☐ POS ☐ PPO	Medical 3	Prescription (Rx) 3
☐ HMO ☐ HSA ☐ POS ☐ PPO	Medical 4	Prescription (Rx) 4
☐ HMO ☐ HSA ☐ POS ☐ PPO	Medical 5	Prescription (Rx) 5

1. Do you or any third party on your behalf, in any way fund or subsidize any portion of a member's cost sharing responsibilities (deductibles, coinsurance, or copays)? ☐ Yes ☐ No

   ☐ No third party arrangement ☐ Gap/Wrap ☐ HSA ☐ Other ______________________

2. Does this group have a flex plan under Section 125 of the Internal Revenue Service Code? ☐ Yes ☐ No

If selecting a HSA Plan, please answer the following below:

Are you contributing toward the cost of a HSA? _________ If "Yes", name of TPA: ____

Name of Bank: ____

SECTION 6: Health Plan of Nevada/Sierra Health Ancillary Benefit Selection

☐ SHL PPO Dental Option 1	☐ SHL PPO Vision Option 1

SECTION 7 : Prior Group Health Benefit Coverage

Does this Health Benefit replace current coverage?	If yes, Carrier is/was:	Termination Date is/was (mm/dd/yyyy)
Health ☐ Yes ☐ No		
Dental ☐ Yes ☐ No		
Vision ☐ Yes ☐ No		

SECTION 8 : Employee Certificates and Group Plan Documents

Employee Certificates:
All Employee documents (EOC / COC / SBC / etc.) will be provided electronically. Members will individually have the option to request printed copy documentation of plan documents once they have enrolled.

Group Plan Documents:

☐ **(Please check here)** I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the group's employees and I confirm that I routinely use electronic communication during the normal course of business. This consent remains in effect until it is withdrawn. The group may withdraw their consent at any time or request a document in a paper or non-electronic form.

SECTION 9: General Agreement

Health Plan of Nevada/Sierra Health and Life:

I, the undersigned, understand and agree that this application is for the healthcare coverage offered by Health Plan of Nevada, and/or Sierra Health and Life Insurance Company, Inc., through an Association Health Plan, and will form a part of any Agreement issued in reliance upon it; and acceptance of the Group for coverage and the final rates are based upon the above information and the census of actual enrollees; and any material misrepresentation therein, will permit HPN and/or SHL to terminate such coverage. I represent that the information contained herein is true and correct. I acknowledge that my Representative has explained the coverage, limitations and exclusions, and other details of the coverage for which I applied. I understand and agree it is my responsibility to offer coverage to all Eligible Employees and their Eligible Family Members and I will provide to HPN, and/or SHL, an Enrollment Form or a Waiver Form signed by each employee within thirty-one (31) days of his/her eligibility date and collect any employee contribution(s) toward any payments/premium due (these documents will become part of this application).

If the information regarding SHL's high deductible Health Benefit Plan is determined to be inaccurate, my Group may be subject to a rate and/or Health Plan change to maintain compliance with SHL's underwriting requirement.

It is also understood that any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received. A one-month deposit is being submitted, to be held without obligation until this application is approved. If the application is approved, the deposit will be applied to the first month's Prepayment Fees/Premium under this Agreement. If coverage does not become effective, the deposit will be refunded. I understand that persons not eligible for coverage are not entitled to enroll in the Plan.

SECTION 10: Representative (Agent/Broker*)

I have explained the coverage, limitations, and exclusions of the coverage for which my client has applied including the Managed Care guidelines and provisions with my client.

**** Note: In order for commissions to be paid, the Agent/Broker must be a member in good standing of the enrolling group's Association.***

Representative (Agent/Broker) 1

Agent/Broker Name			
Agency Name		Federal Tax ID or Social Security Number	
Email Address			
Address	City	State	Zip Code
Phone Number (xxx-xxx-xxxx)	Fax Number (xxx-xxx-xxxx)		
Signature		Date (mm/dd/yyyy)	

SECTION 11: Association Employer Certification

Employer certifies that it meets the requirements listed below to be an employer member of the Association's group health plan under section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA). It understands that it must be a member of the Association in good standing to be eligible to participate in the plan.

Employer further understands that status as an Employer Member, by itself, is not a guarantee of coverage and does not confer upon it the right to participate in the Association's group health plan, which is governed by the by-laws of the Association, the coverage document, the participation agreement and applicable law, including regulations issued under ERISA. Finally, Employer understands that Association's legal documents and applicable law are subject to change.

I certify that each of the following requirements has been met:

Employer certifies that it is a member in good standing of the sponsoring Association and is eligible to participate in the Association's group health plan or Association Health Plan (AHP).

Employer (check each box acknowledging compliance with each)

- ☐ the principal place of business is in Nevada.
- ☐ acts directly as an employer of at least one non-spouse employee who is or will be a participant covered under the plan.

Employer agrees to notify the carrier in the event any factual information that provided the basis for this certification changed or was subsequently determined to not be accurate and understand that the issuer is required by law to monitor compliance with these requirements.

Employer agrees to provide the issuer with documentation to verify the accuracy of the information being certified upon request.

By signing below, I attest to the accuracy, truthfulness and completeness of the information provided herein. I understand that any misrepresentation or fraudulent statement may result in a loss or termination of coverage under the AHP, an increase in the Required Contribution (Payment Amount), or other consequences as permitted by law.

Signature of Group Officer (Name in Section 1 must match)	Date (mm/dd/yyyy)

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance Group for the purpose of defrauding or attempting to defraud the Group, penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance Group or agent of an insurance Group, who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.