Employer Enrollment Application For Small Groups Nevada

Consult the Evidence of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem) and Anthem Life Insurance Company (Anthem Life), its products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary.

Section A: Application Type

☐ New enrollment ☐ Change(s)	Requested effective date (MM/DD/YYYY): / /

Section B: Company Information

Legal company name				Employer tax ID no. (required) – –
Doing Business As (DBA) (if applicable)				
Street address	City	County	State	ZIP code
Billing address — If different from above	City		State	ZIP code
Organization type (Corporation (S or C), Partnership, Proprietorship, etc.): _____				
SIC code — required	Type of business (be specific)	Date business established (MM/DD/YYYY) / /		
Company contact name	Email address	Primary phone no.		
Additional company contact name	Email address			

Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414?
☐ Yes ☐ No If yes, please complete below.

Legal name	Federal tax ID no.	No. of employees employed

Section C: Type of Coverage

Medical Coverage

Choose your medical contribution for each month (only **one** choice is allowed)
☐ Contribution option 1: Traditional option — We will contribute (50% to 100%): _____% per employee _____% per dependent (optional).
☐ Contribution option 2: Percentage of plan option — We will contribute (50% to 100%): _____% to _____ plan.
☐ Contribution option 3: Fixed-dollar option — We will contribute (at least $125) $ _____ per employee and $ _____ per dependent (optional).

For employers providing a Health Savings Account (HSA) option (only **one** choice is allowed)
Do you want Anthem to disclose your group's data to its banking services provider to establish Health Savings Accounts?
☐ Yes (Requires completion of the CDHP questionnaire) ☐ No

Medical plans — Indicate the contract codes for the medical plan(s) selected. The codes can be found on the proposal/quote.

	Medical plan name	Medical contract code
Plan option 1		
Plan option 2		
Plan option 3		
Plan option 4		
Plan option 5		
Plan option 6		

Is this plan intended to replace any existing group medical coverage? ☐ Yes ☐ No
If yes, please complete the information below for each group medical insurance plan you now have.

Insurer	Type of plan (HMO, PPO)	Effective date (MM/DD/YYYY)	Proposed termination date (MM/DD/YYYY)
		/ /	/ /
		/ /	/ /

2. Dental Coverage — Indicate the contract code(s) for the dental plan(s) selected. The codes can be found on the proposal/quote.

Anthem Dental Prime, Anthem Dental Complete, and Anthem Essential Choice with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Dental contract code 1:_____ Dental contract code 2:_____

Choose your dental contribution for each month (optional)**:** _____% per employee _____% per dependent

Select premium level: (Subject to underwriting approval)

☐ Base premium ☐ Bundled premium ☐ Medical Lock premium ☐ Medical Lock and Bundled premium

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No

If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, EPO, PPO)	Effective date (MM/DD/YYYY)	Proposed termination date (MM/DD/YYYY)
		/ /	/ /
		/ /	/ /

Medical Lock (Packaged Enrollment): Enrollment and tiering must be identical on both the Anthem medical and Anthem dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

3. Vision Coverage — Indicate the contract code(s) for the vision plan(s) selected. The codes can be found on the proposal/quote.

Vision contract code 1: _____ Vision contract code 2: _____

☐ Employer-Sponsored Plans ☐ Voluntary Plans

Choose your vision contribution for each month (optional)**:** _____% per employee _____% per dependent

Select premium level: (Subject to underwriting approval)

☐ Base premium ☐ Bundled premium ☐ Medical Lock premium ☐ Medical Lock and Bundled premium

Medical Lock (Packaged Enrollment): All members enrolled in an Anthem medical plan must enroll in Anthem vision. Tiering must be identical on the medical and vision plans. Example: enrollees with Single medical coverage must also have Single vision coverage; enrollees with Family medical coverage must also have Family vision coverage.

4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage (Anthem Life) — Select all that apply. A minimum of two employees must enroll.

Life/AD&D products		Disability products	
Select products and group contribution percentage:		**Select products and group contribution percentage:**	
Product choice	**Percentage**	**Product choice**	**Percentage**
☐ None		☐ None	
☐ Basic Life and AD&D	_____%	☐ Short Term Disability	_____%
☐ Basic Dependent Life	_____%	☐ Long Term Disability	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%	☐ Voluntary Short Term Disability*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%	☐ Voluntary Long Term Disability*	_____%
*Available for Groups of 10+		*Available for Groups of 10+	

If disability benefits are selected, indicate whether the employee pays disability premiums on a pre or post tax basis. If it varies by class, attach a separate sheet with details by class.

Short Term Disability	**Voluntary Short Term Disability**	**Long Term Disability**	**Voluntary Long Term Disability**
☐ Pre Tax	☐ Pre Tax	☐ Pre Tax	☐ Pre Tax
☐ Post Tax	☐ Post Tax	☐ Post Tax	☐ Post Tax

Short Term Disability

1. Do you have any employees who work in New York? ☐ No ☐ Yes – If yes and you want us to be your state-mandated NY Disability Benefit Leave/Paid Family Leave carrier, an additional application and proposal are required.
2. Do you have any employees who work in New Jersey? ☐ No ☐ Yes – If yes and you want us to be your state-mandated NJ Temporary Disability Benefit carrier, an additional application and proposal are required.

Life/AD&D and/or Disability Eligibility Probationary Period/Waiting Period

Would you like to waive the eligibility probationary period/waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility probationary period/waiting period for new eligible employees enrolling in Life/AD&D and/or Disability plans after the group's coverage effective date the same as the medical policy eligibility period? ☐ Yes ☐ No
If no, enter the Life/AD&D and Disability eligibility probationary period/waiting period below.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Will rehired employees be eligible to reinstate their Life/AD&D and/or Disability coverage at the level of coverage they had on their last day worked?
☐ Yes ☐ No
If yes, length of time the group has to rehire an employee under this provision: ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

Prior Coverage

Has this group had life/AD&D, optional life, voluntary life, and/or disability coverage within 30 days of this application's signature date?
☐ Yes ☐ No

Will this plan replace current	Insurance Company Name - Policy/Contract Number	Termination date (MM/DD/YYYY)
Life/AD&D coverage ☐ Yes ☐ No		/ /
Disability coverage ☐ Yes ☐ No		/ /

Participation Requirements — Refer to the Proposal for life and disability participation requirements.

Section D: Eligibility[1]

An employee not actively at work on the life, AD&D, or disability policy effective date or the employee's eligibility date will not be covered until such employee returns to active work.

1. Average total number of employees during the prior calendar year (including employed owners/officers):_____
2. Number of eligible full-time employees (minimum 30 hours per week):_____
3. Number of employees enrolling in:

   Medical:_____ Dental:_____

   Vision:_____ Life/Disability:_____
4. Number of eligible DECLINING employees:_____
5. Number of INELIGIBLE employees:_____
6. Number of employees working outside of NV: _____
7. Will coverage be restricted to a certain classification of employees?
   ☐ Yes ☐ No

   If yes, please explain what class(es):

   _____
8. Probationary period/waiting period for **new employees** for Medical/Dental/Vision:
   ☐ First of month after hire date ☐ 1 month ☐ 2 months

   The standard effective date is first of the month following the waiting period/probationary period.

   Would you like to offer the probationary/waiting period by class?
   ☐ Yes ☐ No

   If yes, please explain classes:

   Class 1: _____ Waiting period: _____

   Class 2: _____ Waiting period: _____
9. Probationary period/waiting period for **rehire** employees: Coverage is reinstated back to the date of the loss of coverage if rehired within 31 days of the loss of employment. If re-hire date is within 92 days of lay-off or termination of employment, the probationary period will be waived and the employee's coverage will be effective the date of rehire. If the employee is hired back after 92 days, then the employee must serve the group's probationary period for new employees.
10. Would you like to waive the probationary period for ALL existing employees at initial enrollment?
    ☐ Yes ☐ No
11. Do you wish to offer coverage for Domestic Partners?
    ☐ Yes ☐ No
12. Under the Medicare Secondary Payer rules, which one applies for your group?
    ☐ Medicare is primary (less than 20 employees)
    ☐ Anthem is primary (20 or more employees)

    Anthem is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
13. Is your company currently subject to COBRA (employed 20 or more total employees on at least 50% of the working days in the previous calendar year)? ☐ Yes ☐ No
14. How many months are employees eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum six months)?
    ☐ None ☐ 1 month ☐ 2 months ☐ 3 months

    ☐ 4 months ☐ 5 months ☐ 6 months
15. How many months are employees eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum three months)?
    ☐ None ☐ 1 month ☐ 2 months ☐ 3 months
16. We, the Employer, attest that the Employer Group named on this application is a Nevada Small Group consistent with the definition below.
    ☐ Yes ☐ No

1 NV law defines small employer as follows:
The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. This section does not apply to Life and Disability insurance.

Section E: Electronic Access of Group Information by Agent/Producer/Broker/General Agent

We, the employer, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem or HMO Nevada to access the group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/producer/broker/general agent is also hereby authorized to use the EmployerAccess system of Anthem or HMO Nevada to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and/or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker/general agent changes.

The agent/producer/broker/general agent must maintain original employee/member enrollment documentation, and shall make them available upon Anthem's request.

Select this box ☐ ONLY if the employer DOES NOT want to authorize the agent/producer/broker/general agent to access and change the group's information on behalf of the group. **Do not select this box if you consent.**

Section F: General Terms and Agreements — Please read this section carefully before signing the application. In this section, "Anthem" and "Company" refers to Anthem Blue Cross and Blue Shield, HMO Nevada, and Anthem Life Insurance Company.

Standard Open Enrollment for Employees: The standard open enrollment period is at least 31 days before the group's renewal date and 31 days after, no more often than once in any 12 consecutive months. The open enrollment period does not apply to life and disability products.

The undersigned employer and/or authorized representative(s) hereby request(s) that it be approved for insurance coverage issued by Anthem. Employer understands and represents, by way of its authorized representatives, that to the best knowledge and belief the entire application for Group Insurance has been reviewed, all answers contained herein are true and complete, and agrees:

1. The employer must maintain records and furnish to Anthem or their designated agent(s), and information required in connection with administration of the coverage. Original source documents, including but limited to employee/member enrollment documentation, shall be made available upon Anthem's request.
2. The requested coverage is not in effect until this application is approved by Anthem, the insurer; that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer; and an employee's coverage is not in effect unless and until the employee application is approved for coverage by the insurer. The employer must meet the minimum enrollment, participation and eligibility requirements according to the applicable Anthem underwriting policies and Nevada state law.
3. For the insurer to accept this application, all the information requested on this application must be completed. If the application is not complete, the insurer or their designated agent(s) are authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by the insurer may be different from the coverage applied for herein. If the insurer notifies the employer of such different coverage, and the employer pays the appropriate premium, the employer will be deemed to have accepted the coverage as issued.
4. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under Anthem Life trust policy(ies), if applicable;
5. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
6. To maintain records and furnish to company or their designated agent(s), any information required in connection with administration of the insurance coverage;
7. To provide notice of applicable conversion and/or portability rights to eligible employees and eligible dependents;
8. That statements of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Company for life and disability insurance;
9. That approval for this insurance may cancel any prior contracts and/or coverage with Company effective immediately preceding the effective date of the employer's coverage;
10. To pay Company by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
11. That claims filed by or on behalf of members may, at Company's option, be suspended if premiums are not received timely;
12. The employer will receive, on behalf of members, all notices delivered by Company, and immediately forward such notices to persons involved, at their last known address;

13. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Company's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these Conditions are met, there shall be no liability on the part of Company, except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
14. That in order for Company to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Company, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Company may be different than the coverage applied for herein. In that event, Company shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
15. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Company by the employer. Company reserves the right to review such rates upon receipt of all individual applications and modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
16. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Company in writing) and meet any other eligibility requirements for coverage;
17. That an employee not actively at work on the policy effective date or the employee's eligibility date will not be covered until such employee returns to active work.
18. The requested coverage is not in effect unless and until this application is approved by Company, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Company.
19. By signing below, I, the employer, agree that Anthem can deliver plan materials and related items, including but not limited to benefit booklets, summaries, billing statements, notices of non-payment and cancellation and other notices, via email or other electronic means. I agree that I will provide and update Anthem with a current email address. I understand that at any time I can request a free copy of these materials by mail, by contacting Anthem at 1-800-922-4770. I also agree that by providing Anthem with an employee or participant's e-mail address, the employer thereby represents that: (1) the employer has the employee's consent to receive plan documents (including explanation of benefits, claim denials and life and disability Evidence of Insurance underwriting documents) electronically; (2) the employee has reasonable access to the electronic communication at work; and (3) the employer obtained the employee consent using Anthem's application form or in a manner that clearly and conspicuously described the types of communications which can be made electronically, any hardware or software required to access those communications, the ability and process to change email addresses or withdraw consent and request a paper copy or otherwise in a manner that complies with applicable state and federal law regarding electronic delivery of plan materials and adverse benefit determinations.

Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal penalties.

Sign here	Company officer signature **X**	Title	
	Printed name		Today's date (MM/DD/YYYY) / /
Accepted by officer of Anthem and/or Anthem Life			Today's date (MM/DD/YYYY) / /

Section G: Agent/Producer/Broker Certification

1. I am not aware of any information not disclosed by the employer in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem and/or HMO Nevada and/or Anthem Life to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem and/or HMO Nevada and/or Anthem Life reviews and approves the application and the employer receives a written notice from Anthem and/or HMO Nevada and/or Anthem Life.
5. I am the appointed agent/broker and am receiving commissions for the submission of this employer. No portion of my commission payments from Anthem and/or HMO Nevada and/or Anthem Life shall be paid to an agent/broker/producer who is not appointed/approved by Anthem and/or HMO Nevada and/or Anthem Life.
6. I have advised the employer not to terminate any existing coverage until receiving written notification from Anthem and/or HMO Nevada and/or Anthem Life that the coverage being applied for by this application is accepted.

Writing agent			%	**Second writing agent**			%
Agency name		Agency ID no.		Agency name		Agency ID no.	
Agent name				Agent name			
Agent/producer/broker Tax ID/SSN				Agent/producer/broker Tax ID/SSN			
Street address				Street address			
City	State	ZIP code		City	State	ZIP code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature	Today's date (MM/DD/YYYY) / /			Signature	Today's date (MM/DD/YYYY) / /		
For General Agent use only							
General agent name				Federal tax ID no. or Social Security no.			
Street address				City	State	ZIP code	
Sales Representative and Account Manager							
Sales representative name				Sales representative ID no.			
Account manager name				Account manager ID no.			

ANTHEM USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY) / /