Prominence®
Health Plan

NEVADA SMALL GROUP MASTER APPLICATION

Addendum to the Employer Group Contract

All required group submission materials, including but not limited to employee enrollment forms, waivers, group master application and binder check must be submitted no later than the 25th of the month preceding the effective date. If all required materials are not submitted by the effective date of coverage, the group's effective date will be moved to the following month and rates will change accordingly.

SECTION 1: PURPOSE			**REQUESTED EFFECTIVE DATE**
☐ Submit a new application ☐ Request change(s) for group no.			(mm/dd/yyyy)
Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Physical Street Address (P.O. Box not acceptable)	City	State	ZIP
Billing Address (if different than above)	City	State	ZIP
Phone Number	Fax Number		
State of Domicile			
Are there common ownership or affiliate companies? If so, please list:			
Company Contact Name			
Company Contact Title	Company Contact E-mail Address		
Billing Contact Name (if different from Company Contact)	Billing Contact E-mail Address		
Enrollment Contact Name (if different from Company Contact)	Enrollment Contact E-mail Address		

SIC Code	Nature of Business	Federal Tax ID Number	Date Business Established (MO/YR):

Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Other: _____

SECTION 2: MEDICAL COVERAGE SELECTION – PHP Medical Plans

Designated Plan(s) – For Small Groups the mandatory minimum hourly requirement for offering health benefits is 30 hours per week. Employers can offer up to three (3) available plans under the condition that there is enrollment within each plan. Please indicate your plan(s) of choice below:

Small group plan name

1. _____ 3. _____

2. _____

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

SECTION 3: WORKERS' COMPENSATION

Does your company offer Workers' Compensation?	☐ Yes ☐ No

SECTION 4: EMPLOYER/EMPLOYEE CONTRIBUTION(S)

Coverage	**Medical**
Employer Contribution for Employee	$_____ per Month OR _____% Employee
Employer Contribution for Dependent	$_____per Month OR _____% Dependent

1510 Meadow Wood Lane, Reno, Nevada 89502
www.prominencehealthplan.com

Approval date: 01/19/2017
Effective date: 01/01/2017

SECTION 5: ACA FULL-TIME EQUIVALENT REQUIREMENT

The collection and reporting of this data is required under the Employer Shared Responsibility Provision (ESRP) of Affordable Care Act (ACA). Health insurers require this data to ensure proper underwriting and reporting for all New Business and Renewing Groups. Employers are considered "Applicable Large Employers", also referred to as ALE's, if they employ 50 or more full-time employees or a combination of full-time and part-time employees that equals 50 full-time equivalent employees.

MONTH	Step 1: Column X *Number of Full-Time Employees*	Step 2: Column Y *Total Hours Worked by Part-Time Employees*	Step 3: Column Z *Column Y divided by 120*
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			
Subtotals:	**X Column Subtotal =**		**Z Column Subtotal =**
Step 4:	**X + Z / 12 = _____ The numerical result of Step 4 equals the group size. If the group is equal to or less than 50, the group is considered small group.**		

SECTION 6: ELIGIBILITY – Please tell us more about your group

A. How many employees (including employed owners/officers) work at least 30 hours/week, not including those working on a temporary or seasonal basis? _____

B. How many are enrolling in this employer's groups coverage? _____

C. How many employees are currently in the required probationary/waiting period? _____

D. How many are enrolling in group coverage elsewhere, or have an individual policy? _____

E. How many are waiving coverage? _____

F. How many work or live outside the state of Nevada? _____

G. Would you like to offer coverage for domestic partners? ☐ Yes ☐ No
Under Nevada law, employers may voluntarily provide coverage to domestic partners.

H. Please identify the probationary/waiting period for new employees (not to exceed 90 days from date of hire). **First of the month following:**

☐ All employees OR ☐ Class 1: _____
☐ Date of hire ☐ 30 days ☐ 60 days ☐ no waiting period (coverage begins on date of hire)

☐ Class 2 (if applicable): _____
☐ Date of hire ☐ 30 days ☐ 60 days ☐ no waiting period (coverage begins on date of hire)

I. Would you like to waive the probationary period for ALL existing employees at initial enrollment? ☐ Yes ☐ No

J. Rehire policy:
☐ Same as New Hire WP ☐ Immediate
☐ First of the month following _____days(s) of employment

K. Leave of absence policy:
☐ Same as New Hire WP ☐ Immediate
☐ First of the month following _____days(s) of employment

L. Coverage terminates for employee(s): ☐ Last day worked ☐ Last day of the month

M. Is your company currently subject to COBRA? (Employed 20 or more employees on at least 50% of working days in previous calendar year.) ☐ Yes ☐ No

N. How many employees are currently on COBRA? _____

O. Under TEFRA/DEFRA, which one applies to your group? (Based on total number of employees during 50% of the working days in previous calendar year.)
☐ Medicare is primary (for groups with less than 20 employees)
☐ Prominence Health Plan is primary (for groups with more than 20 employees)

SECTION 7: PREVIOUS HEALTH COVERAGE

Will this plan replace current Health coverage? ☐ Yes ☐ No	If yes, the carrier is/was: _____	Termination date is/was (mm/dd/yyyy): _____

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SECTION 8: GENERAL AGREEMENT

I have conspicuously posted or distributed to all employees the "THE NOTICE OF A CHANGE IN GROUP COVERAGE" at least 15 days prior to the requested effective date in such a way to ensure all modifications have been posted or distributed on the group health plan.

I, undersigned, understand and agree this application is for the health care coverage offered by Prominence Health Plan, and will form a part of any contract issued in reliance upon it; and acceptance of the group for coverage and final rates are based upon the above information and the census of actual enrollees; and any material misrepresentation therein, whether intentional or unintentional, will permit Prominence Health Plan, to terminate such coverage. I acknowledge my Representative has explained the coverage's limitations and exclusions and other details of the coverage applied for; and I have read and understand the Nevada Statutory Disclosures. I understand and agree it is my responsibility to offer coverage to all eligible employees and their dependents (when eligible); and I will provide to Prominence Health Plan, an enrollment form or a waiver of coverage form signed by each employee within 31 days of his/her eligibility date; and collect any employee contribution(s) toward premium. I understand and agree my group must maintain a minimum participation and contribution level for the coverage.

It is also understood any existing coverage presently being provided to employees should not be cancelled 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 premium under the policy. If coverage does not become effective, the deposit will be refunded.

Mediation and Arbitration Agreement
Group and Preferred Health Insurance Company (collectively, the "Parties") agree to mediate all unresolved disputes and claims. The Parties agree that if mediation is not successful they will arbitrate any and all disputes. **The Parties further agree that any arbitration under this Agreement will take place on an individual basis; Class Arbitration and Class Actions are not permitted.** A complete description of the Mediation/Arbitration Agreement is contained in the Employer Group Contract.

YOUR INITIALS REQUIRED _____

SECTION 9: SIGNATURES

Name of company officer (Please print)	Title of company officer
Signature of company officer	Date (mm/dd/yyyy)

SECTION 10: AGENT CERTIFICATION – Please ask your agent to complete this section

1. I am not aware of any information not disclosed by the client 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 Prominence Health Plan 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 Prominence Health Plan reviews and approves the application and the employer receives a written notice from Prominence Health Plan.
5. I am the appointed agent and am receiving commissions for the submission of this client. No portion of my commission payments from Prominence Health Plan shall be paid to an agent/producer not appointed/approved by Prominence Health Plan.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Prominence Health Plan that the coverage being applied for by this application is accepted.

11a. Writing Agent		%	**11b. Second Writing Agent**		%
Name			Name		
Federal Tax ID no. or Social Security no.			Federal Tax ID no. or Social Security no.		
Address			Address		
City	State	ZIP code	City	State	ZIP code
Phone			Phone		
E-mail address			E-mail address		
Signature		Date	Signature		Date