Prominence®
Health Plan

NEVADA LARGE GROUP MASTER APPLICATION

Addendum to the Employer Group Contract

SECTION 1: PURPOSE			REQUESTED EFFECTIVE
☐ 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 – Medical Plans

Please complete your medical plan selection(s) along with corresponding pharmacy selection(s). Plans subject to Underwriting approval:

Plan 1 Medical Plan Name _____ Plan 1 Rx Tiers _____
Employer Contribution for Employee $____ per month OR _____% employee AND Employer Contribution for Dependent $_____ per month OR _____% dependent

Plan 2 Medical Plan Name _____ Plan 1 Rx Tiers _____
Employer Contribution for Employee $____ per month OR _____% employee AND Employer Contribution for Dependent $_____ per month OR _____% dependent

Plan 3 Medical Plan Name _____ Plan 1 Rx Tiers _____
Employer Contribution for Employee $____ per month OR _____% employee AND Employer Contribution for Dependent $_____ per month OR _____% dependent

Plan 4 Medical Plan Name _____ Plan 1 Rx Tiers _____
Employer Contribution for Employee $____ per month OR _____% employee AND Employer Contribution for Dependent $_____ per month OR _____% dependent

Plan 5 Medical Plan Name _____ Plan 1 Rx Tiers _____
Employer Contribution for Employee $____ per month OR _____% employee AND Employer Contribution for Dependent $_____ per month OR _____% dependent

1. Do you, or any third party on your behalf, in any way fund or subsidize any portion of the member's cost sharing responsibilities (deductibles, coinsurance or copays)?
Select types of funding arrangements that apply: ☐ No third party arrangement ☐ Gap ☐ Wrap ☐ HSA ☐ HRA ☐ Other _____
If "Yes," Carrier used and how much? _____
Or do you offer a group or voluntary GAP plan, disease specific, or other type of ancillary medical coverage? ☐ Yes ☐ No
List Carrier name, including GAP plan product description _____

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

SECTION 3: WORKERS' COMPENSATION

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

SECTION 4: 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. Full-time equivalent employees (FTEs) is based on the total full-time and part-time employees. The table below enables an employer to calculate FTEs.

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 more than 51, the group is considered large group.		

SECTION 5: 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 work or live outside the state of Nevada? _____

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

G. Does your company have a policy that if a spouse is offered coverage by their employer, they are not an eligible dependent? ☐ Yes ☐ No

H. Please identify the probationary/waiting period for **new employees** as being the **first of the month** after (not to exceed 90 days from date of hire):
☐ All employees OR ☐ Class 1: _____
☐ hire date ☐ 30 days ☐ 60 days ☐ no waiting period
(coverage begins on date of hire)
☐ Class 2 (if applicable): _____
☐ hire date ☐ 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. Coverage terminates for employee(s): ☐ Last day worked ☐ Last day of the month

K. Please identify the probationary/waiting period for **rehire employees** as being the **first of the month** after:
☐ rehire date ☐ 30 days ☐ 60 days ☐ no waiting period
(coverage begins on date of rehire)

L. 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

M. 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

N. How many employees are currently on COBRA or are within their COBRA election or eligibility period? _____

SECTION 6: 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): _____

SECTION 7: 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, including claims reports, and / or group and individual health questionnaires; and any material misrepresentation therein, whether intentional or unintentional, will permit Prominence Health Plan, to revise rates or terminate coverage. I acknowledge my Representative has explained the coverage, 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; 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 an agreed upon minimum participation and contribution level for the coverage or rates may be revised.

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.

YOUR INITIALS REQUIRED _____

SECTION8: SIGNATURES

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

SECTION 9: AGENT CERTIFICATION – Please ask your agent to complete this section

1. I do not have knowledge disclosed by the client, or otherwise, that has bearing on the group's 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