Prominence® Health Plan

LARGE GROUP APPLICATION & RENEWAL/CHANGE FORM

Addendum to the Employer Group Contract

SECTION 1: GROUP INFORMATION

☐ Submit a new application ☐ Renewal: No Changes	☐ Update to existing group Group #: _____	Coverage period (MM/DD/YYYY - MM/DD/YYYY) _____
Update/change applicable to: ☐ Medical ☐ Dental ☐ Vision ☐ COBRA/FSA/HRA/DCRA		Effective Date of Change (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		Website Address	

Are there common ownership or affiliate companies? If so, please list and include for each group the percentage of common ownership and owner:

Primary Contact Name

Primary Contact Phone	Primary Contact Email
Group Administrator Contact Name (if different from Company Contact)	Group Administrator Contact Email

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

Employer Classification: ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Public Entity

☐ Other: _____

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

SECTION 2: ASSOCIATION HEALTH PLANS (if applicable)

This section is required for those groups enrolling within a Prominence Association Health Plan.

Indicate the name of the Association of which you are applying for coverage:

Are you a current member of this Association?* ☐ Yes ☐ No

If "No", please contact the appropriate association for membership details. A group must be an established member of a partnering association in order to be eligible for Association Health Plan benefits.

If "Yes", please submit proof of membership with this application to determine eligibility status. Prominence Health Plan cannot process your application without this information.

* Active association membership is required through-out the tenure of your insurance contract period. If such membership becomes invalid, please note that the terms of your insurance may be reviewed and rescinded.

How is your organization affiliated with this Association? For example - Our business provides linen services to hotels through the Nevada Hotel Lodging Association.

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SECTION 3: COVERAGE SELECTION

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

Plan 1 Medical Plan Name	Plan 1 Rx Tiers
Plan 2 Medical Plan Name	Plan 2 Rx Tiers
Plan 3 Medical Plan Name	Plan 3 Rx Tiers
Plan 4 Medical Plan Name	Plan 4 Rx Tiers
Plan 5 Medical Plan Name	Plan 5 Rx Tiers
Dental Plan 1	Dental Plan 2
Vision Plan 1	Vision Plan 2

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)? ☐ Yes ☐ No

Select types of funding arrangements that apply: ☐ GAP ☐ Wrap ☐ HSA ☐ HRA ☐ Other _____

If "Yes," carrier used and how much? _____

SECTION 4: WORKERS' COMPENSATION

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

If "Yes," please include carrier name: _____ Policy number: _____

SECTION 5: EMPLOYER/EMPLOYEE CONTRIBUTION(S)

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

SECTION 6: ELIGIBILITY & COVERAGE ELECTIONS

A. Will this plan replace current health coverage ☐ Yes ☐ No

If "Yes," the carrier/administrator: _____ Termination date (MM/DD/YYYY): _____

B. Please designate the number of: Full Time Employees _____ Part Time Employees _____

The employer requires that all eligible employees have a regular workweek of at least _____ hours per week.
Eligible employees do not include those employed on a part-time or seasonal basis.

Please provide the number of eligible employees for your organization _____

Is coverage restricted to certain classification(s) of employees? ☐ Yes ☐ No

If "Yes," explain: _____

If "No," specify eligibility rules: _____

C. How many employees are enrolling in this employer's group coverage?

D. How many enrolled employees live outside the state of Nevada?

E. How many employees are waiving without coverage? _____

How many employees are waiving with creditable coverage? _____

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

G. Coverage terminates for employees: ☐ Last day worked ☐ Last day of the month

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MEDICAL COVERAGE EFFECTIVE DATES

A. How many employees are currently in the required probationary/waiting period for **medical coverage**? _____

B. Please identify the probationary/waiting period for **medical coverage** for new employees (not to exceed 90 days from date of hire):

Applies to: ☐ All employees OR ☐ Class 1 and define Class 1 _____:
Coverage begins after: ☐ date of hire ☐ 30 days ☐ 60 days ☐ 90 days
Coverage begins on first day of the month following: ☐ date of hire ☐ 30 days ☐ 60 days

Applies to: ☐ Class 2 (if applicable) and define Class 2 _____:
Coverage begins after: ☐ date of hire ☐ 30 days ☐ 60 days ☐ 90 days
Coverage begins on first day of the month following: ☐ date of hire ☐ 30 days ☐ 60 days

C. Is the probationary / waiting period for **medical coverage** for rehired employees the same as new employees? ☐ Yes ☐ No

If "No," please identify the probationary/waiting period for **medical coverage** for rehired employees: _____

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

E. Confirm here if employees remain eligible during an approved leave of absence up to three months. ☐

DENTAL COVERAGE EFFECTIVE DATES

A. How many employees are currently in the required probationary/waiting period for **dental coverage**? _____

B. Please identify the probationary/waiting period for **dental coverage** for new employees (not to exceed 90 days from date of hire):

Applies to: ☐ All employees OR ☐ Class 1 and define Class 1 _____:
Coverage begins after: ☐ date of hire ☐ 30 days ☐ 60 days ☐ 90 days
Coverage begins on first day of the month following: ☐ date of hire ☐ 30 days ☐ 60 days

Applies to: ☐ Class 2 (if applicable) and define Class 2 _____:
Coverage begins after: ☐ date of hire ☐ 30 days ☐ 60 days ☐ 90 days
Coverage begins on first day of the month following: ☐ date of hire ☐ 30 days ☐ 60 days

C. Is the probationary / waiting period for **dental coverage** for rehired employees the same as new employees? ☐ Yes ☐ No

If "No," please identify the probationary/waiting period for **dental coverage** for rehired employees: _____

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

E. Confirm here if employees remain eligible during an approved leave of absence up to three months. ☐

VISION COVERAGE EFFECTIVE DATES

A. How many employees are currently in the required probationary/waiting period for **vision coverage**? _____

B. Please identify the probationary/waiting period for **vision coverage** for new employees (not to exceed 90 days from date of hire):

Applies to: ☐ All employees OR ☐ Class 1 and define Class 1 _____:
Coverage begins after: ☐ date of hire ☐ 30 days ☐ 60 days ☐ 90 days
Coverage begins on first day of the month following: ☐ date of hire ☐ 30 days ☐ 60 days

Applies to: ☐ Class 2 (if applicable) and define Class 2 _____:
Coverage begins after: ☐ date of hire ☐ 30 days ☐ 60 days ☐ 90 days
Coverage begins on first day of the month following: ☐ date of hire ☐ 30 days ☐ 60 days

C. Is the probationary / waiting period for **vision coverage** for rehired employees the same as new employees? ☐ Yes ☐ No

If "No," please identify the probationary/waiting period for **vision coverage** for rehired employees: _____

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

E. Confirm here if employees remain eligible during an approved leave of absence up to three months. ☐

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SECTION 7: GENERAL AGREEMENT

I have conspicuously posted or distributed to all employees the "NOTICE OF A CHANGE IN GROUP COVERAGE" at least 30 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, LLC., and will form a part of any contract issued in reliance upon it. 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 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 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. If 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.

In the event Prominence Health Plan does not receive a signed application within 30 days of the group's effective/renewal date, Prominence will terminate this group plan retroactive to the first of the month, no less than 30-days after the group's effective date.

YOUR INITIALS REQUIRED _____

SECTION 8: SIGNATURES

Name of company officer (please print)	Title of company officer
Signature of company officer	Date (MM/DD/YYYY)
Email address	Phone number

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.

Producer/Writing Agent/Consultant Group %	Producer/Writing Agent/Consultant Group %
Agency name/brokerage	Agency name/brokerage
Federal Tax ID # or Social Security #	Federal Tax ID # or Social Security #

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