Employer Enrollment Application For Small Groups Nevada

Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem), 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)	Form 5500 ID number		
Doing Business As (DBA) (if applicable)				
Local (Physical) 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				
If you have ownership in another company, you may be considered a Single Employer with common ownership under IRS section 414, subsection (b), (c), (m), or (o). Do you qualify as a Single Employer with common ownership under IRS section 414? ☐ Yes ☐ No If yes, please complete below.				

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

Employer tax ID no. (required): _____

Section C: Type of Coverage

1. Medical Coverage

Choose your medical contribution for each month (only **one** choice is allowed)
☐ Contribution option 1: Traditional option — We will contribute _____% per employee (50% to 100%) and _____% per dependent (optional, may be from 0% to 100%).
☐ 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

HSA administrator	Phone no.	Email address

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, and 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: _____

Optional: Choose your dental contribution for each month. We will contribute: _____% 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.

Employer tax ID no. (required): _____

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

Vision contract code: _____ ☐ Employer-Sponsored Plans ☐ Voluntary Plans

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.

Section D: Eligibility[1]

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: _____
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 the 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

Section E: Access of Group Information by Designated Agent/Producer/Broker/Agency/Brokerage/General Agency

We the employer hereby authorize our designated agent, producer, broker, agency, brokerage, general agency and their respective employees currently on file with Anthem or HMO Nevada (Agent) to access our health plan information, including protected health information, on behalf of our health plan through Anthem's or HMO Nevada's EmployerAccess system or any other access points Anthem or HMO Nevada may offer. This information may include, but is not limited to, detail about members, plan selections and bills/invoices. Our Agent is also authorized to make changes to our information on our behalf, including but not limited to adding/deleting plans and members and changing member demographic information. We will be responsible for the activities of our Agent. If our Agent on file changes, these authorizations will apply with respect to our successor Agent. Our Agent is required to maintain all original documentation and will make such documentation available to Anthem upon 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.**

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.

Employer tax ID no. (required): _____

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.

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 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;
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. 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;
8. 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;
9. That claims filed by or on behalf of members may, at Company's option, be suspended if premiums are not received timely;
10. 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;
11. 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;
12. 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;
13. 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;
14. 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;
15. 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.

16. 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.
17. 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 or by contacting Anthem at 1-800-922-4770. I also agree that by providing Anthem with an employee or participant's email address, the employer thereby represents that: (1) the employer has the employee's consent to receive plan documents (including explanation of benefits and claim denials) 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			**Today's date (MM/DD/YYYY)** / /

Employer tax ID no. (required): _____

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 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 reviews and approves the application and the employer receives a written notice from Anthem and/or HMO Nevada.
5. I am the appointed agent/producer/broker and am receiving commissions for the submission of this employer. No portion of my commission payments from Anthem and/or HMO Nevada shall be paid to an agent/producer/broker who is not appointed/approved by Anthem and/or HMO Nevada.
6. I have advised the employer not to terminate any existing coverage until receiving written notification from Anthem and/or HMO Nevada 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 no./SSN			Agent/producer/broker Tax ID no./SSN		
Existing Broker EmployerAccess user name			Existing Broker EmployerAccess user name		
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.	
INTERNAL USE ONLY Group no.	Tracking no.	Effective date (MM/DD/YYYY) / /

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾiਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf