Employer Application
Nevada PPO

Anthem

Section 1: Applicant

Reason for application: ☐ New ☐ Change		Effective date: (MMDDYYYY)	
Medical case no.	Dental case no.	Vision case no.	EAP case no.
Group legal name (including DBA)			
Nature of business		SIC code	Federal tax ID no.
Street address	City	State	ZIP code (5+4)
Group implementation contact name	Group implementation contact phone no.	Group implementation contact email address	
Form of organization: _____		Number of years in business: _____	
Does the employer have a cafeteria plan under IRS section 125? ☐ Yes ☐ No			
If your HSA plan includes cash incentives paid directly to the HSA account, I acknowledge that I offer benefits through a Section 125 Cafeteria plan. Initials: _____			
Employees of the following subsidiaries or affiliates are to be included — Please attach a separate sheet for additional locations.			
Company name: _____	Address: _____		
Company name: _____	Address: _____		

Section 2: Coverage — Select all plans that will be offered and attach your quote/proposal to the application.

Coverage		Specific plan	Employer contribution (Enter %) Employee	Dependent
Medical				
	☐ Add HRA Wrap (Administered by Anthem) 100+			
Dental				
Vision				
EAP				N/A
Health and Wellness				
CDHP accounts				

Section 2: Coverage — Continued

Coverage		Specific plan	Employer contribution (Enter %) Employee	Dependent
Accident Critical Illness Hospital Indemnity				

Does the Group have different enrollee classes (management vs. hourly, administration employees vs. field employees, etc.)? ☐ Yes ☐ No
If so, please provide us the different class break-outs on a separate sheet of paper.

Will the different classes have different Group contribution amounts? ☐ Yes ☐ No
If so, please provide the contribution amounts for each class on a separate sheet of paper.

Will the different classes have different plan designs or benefit amounts? ☐ Yes ☐ No
If so, please provide the plan designs or benefit amounts for each class on a separate sheet of paper.

Does the Group self-fund any portion of the deductible, copayments, or cost-shares? ☐ Yes ☐ No If yes, how much?

Who should Anthem bill the active (non-COBRA) invoices to? ☐ Group ☐ TPA
If the Group wants Anthem to send the invoice directly to the TPA, please ensure the TPA section of the Group Implementation Questionnaire is completed.

Who should Anthem bill the COBRA invoices to? ☐ Group ☐ TPA
If the Group wants Anthem to send the invoice directly to the TPA, please ensure the TPA section of the Group Implementation Questionnaire is completed.

For employers providing a Health Savings Account (HSA) option:
Do you want Anthem to disclose your group's data to its banking services provider to establish Health Savings Accounts? ☐ Yes ☐ No
If yes, requires completion of questionnaire.

Section 3: Contribution and minimum enrollment percentage requirements

Anthem Blue Cross and Blue Shield recommends that the employer contribution be at least 50% of the employee rate for the least expensive benefit plan offered for all active employees who are enrolled in the group health plan. The rates for the benefits provided assume that at least 50% of the eligible employees and 75% of Net Eligible employees will participate in the plan.

Section 4: Prior coverage

Is there other coverage being replaced? ☐ Yes ☐ No If yes, please indicate the carrier and coverage information being replaced.

Name of prior **Medical** carrier	Type of coverage being replaced (i.e. HMO, PPO)	Prior carrier's annual deductible (if applicable)
Name of prior **Dental** carrier	Type of coverage being replaced (i.e. HMO, PPO)	Start date/end date

Section 5: Eligibility and enrollment

Eligible participants are:
- ☐ Active full-time employees working ____ hours per week
- ☐ Active part-time employees working ____ hours per week
- ☐ Retirees (Retirees must be covered under group plan prior to retirement, and retiree coverage is subject to Underwriting approval.)
- ☐ Full-time or part-time students going to school with at least ____ credit hours
- ☐ Other — Please list other here:

Total number of eligible employees or subscriber participants enrolling in the Anthem plans:	
Total number of employees or subscriber participants eligible for employer-sponsored health plan:	
Total number of eligible employees or subscriber participants covered under other non-Anthem health plan:	
Total number of employees or subscriber participants (regardless of status who are covered, not covered or covered elsewhere):	

Plan type (check all that apply) ASO plan? ☐ Yes ☐ No Form 5500 no.: ____

ERISA	**Non-ERISA**
☐ For profit entity plan	☐ Religious entity plan
☐ Non-profit entity plan	☐ Government entity plan
☐ Partnership-partners and employees plan	☐ Partnership-partners only
☐ Tribes – employees plan	☐ Tribes – members
	☐ Workers' compensation/unemployment

If you selected Non-ERISA, is your employer plan? ☐ Public ☐ Private

Section 6: Waiting period

All products sold or medical only

If a waiting period with an asterisk is selected, Anthem will adjust the coverage effective date to ensure the waiting period between enrollees' eligibility date and the effective date of their coverage does not exceed 90 days from date of hire.

Waiting period for:

Eligibility/coverage begin date:

Notes:

Specialty products only

Waiting period for:

Eligibility/coverage begin date:

Notes:

Would you like to waive the waiting period for initial enrollment? ☐ Yes ☐ No
(i.e., all active full-time employees who have or have not met their probationary period can enroll.)

Section 7: Eligible dependents

Do you want to offer domestic partner coverage? ☐ Yes ☐ No

Dependent Children — Dependent children are covered until the end of the month in which they become age 26. Unmarried dependent children age 26 or older may be covered as specified by the Certificate. If the Group wishes to cover dependent children beyond age 26, please provide the guidelines which the Group imposes.

Enter guidelines below, if applicable:

Section 8: Electronic services

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 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.

We, the Group, 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.

☐ Check this box ONLY if the Group elects to opt-out of authorizing the agent/producer/broker/general agent to access and change the Group's information on behalf of the Group.

Section 9: Broker information

Brokerage name			Brokerage tax ID no.
Brokerage street address	City	State	ZIP code
Brokerage phone no.	Broker status: ☐ New ☐ Existing		

Broker commission Broker commission per contract per month: _____ PCPM or Medical commission percentage: _____%
Dental: _____% Vision: _____% EAP: _____% Is the above commission standard? ☐ Yes ☐ No
Commissions to be paid to: ☐ Broker ☐ Brokerage ☐ General Agent ☐ General Agency
Anthem Broker Number of the agent or agency receiving commissions: _____

Broker Certification — I hereby certify:

1. I have reviewed the attached employee and employer applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications 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 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 or HMO Nevada reviews and approves the application and the employer receives a written notice from Anthem or HMO Nevada.
5. I am the appointed broker and am receiving commissions for the submission of this client. I have disclosed to the applicant all compensation I will or may be eligible to receive as a result of the applicant's business. Absent the written signed consent of Anthem, no portion of my commission payments from Anthem shall be paid to a broker/producer not appointed/approved by Anthem.

Authorized **Broker of Record** signature X	Printed name	Date (MMDDYYYY)
Broker tax ID no.	Broker email address	
Authorized **General Agent** signature X	Printed name	Date (MMDDYYYY)
General agent tax ID no.	General agent email address	

Section 10: General agreement — Read carefully

Upon acceptance of the application, the Group will inform all persons who are eligible for coverage that they may apply for Anthem Blue Cross and Blue Shield (Anthem) or HMO Nevada coverage under the Agreement/Policy.

Application is hereby made to Anthem or HMO Nevada, or the appropriate affiliated company, for a Group Benefit Agreement/Group Policy providing health service benefits. If this application is accepted, an Agreement/Policy will be issued which will set forth the terms, benefits and conditions of the relationship between the Group and Anthem or HMO Nevada. This application will become part of that Agreement/Policy.

It is understood that no agent or representative except the President, a Vice President, or the Secretary has power on behalf of Anthem or HMO Nevada to bind Anthem or HMO Nevada to accept risk, issue an Agreement/ Policy, or commit to particular provisions of an Agreement/ Policy. The quote/proposal along with this application will become part of the Agreement/Policy. No coverage will come into effect unless and until this application is accepted. If accepted, the terms of the relationship will be defined entirely within an Agreement/ Policy.

The Group agrees that by signing this document, they are representing themselves as a large employer group as defined by applicable law and that it understands that by electing to apply for the above products it may be ineligible to later select small group plan options.

ARBITRATION AGREEMENT

IF THE GROUP IS NOT SUBJECT TO ERISA, ANY DISPUTE BETWEEN A PERSON COVERED UNDER THE AGREEMENT/POLICY AND ANTHEM BLUE CROSS AND BLUE SHIELD (ANTHEM), INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS NEVADA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE PERSON COVERED AND ANTHEM ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. IF THE GROUP IS SUBJECT TO ERISA, DISPUTES INVOLVING AN ADVERSE BENEFIT DETERMINATION FOR A HEALTH CLAIM ARE NOT SUBJECT TO BINDING ARBITRATION, BUT, MUST FOLLOW THE ERISA CLAIMS APPEAL PROCESS.

Employer/Group signature

I understand and agree to all of the above.

Authorized Group signature X	Printed name of officer, partner or proprietor	Title	Date (MMDDYYYY)

Reset Form Save and Print