nhc nevada health co-op simply better

SMALL GROUP ENROLLMENT AGREEMENT

Group/Company Information				
Group Name (Company Name):			Group Effective Date:	
Business Name:			Phone:	
Business Address:				
City	State	Zip Code	Fax:	
Nature of Business		Sic Code	Federal Tax ID#	
Mailing and Billing Address				
City			State	Zip
Group Benefit Administrator		Title	Phone	
Email			Fax:	
Billing Contact		Title	Phone	
Email			Fax:	
Additional Contact		Title	Phone:	
Email			Fax:	

Enrollment Criteria		
Total # of Employees:	Total Eligible Employees:	Total Employees Enrolling
Group must submit enrollment forms for newly eligible employees prior to employees effective date		
Previous Carrier Detail:		
Carrier Name	Effective Date	Termination Date

NOTE: Premium rates & policies are guaranteed for 12 months from the original effective date.

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Health Plans (check all that apply)	
☐ Southern Simple/Fácil Platinum	☐ Southern Simple/Fácil Gold H.S.A.
☐ Southern Simple/Fácil Gold	☐ Southern Simple/Fácil Bronze H.S.A.
☐ Southern Simple/Fácil Silver	☐ Northern Simple/Fácil Bronze H.S.A.
☐ Southern Simple/Fácil Bronze	☐ Frontier Simple/Fácil Bronze H.S.A.
☐ Northern Simple/Fácil Platinum	☐ VIP Platinum
☐ Northern Simple/Fácil Gold	☐ VIP Gold
☐ Northern Simple/Fácil Silver	☐ VIP Silver
☐ Frontier Simple/Fácil Platinum	☐ Union Star/Estrella Platinum
☐ Frontier Simple/Fácil Gold	☐ Union Star/Estrella Gold
☐ Frontier Simple/Fácil Silver	☐ Union Star/Estrella Silver
☐ Southern Star/Estrella Platinum	☐ Connected/Conectado Platinum
☐ Southern Star/Estrella Gold	☐ Connected/Conectado Gold
☐ Southern Star/Estrella Silver	☐ Connected/Conectado Silver

Employer Contribution	
Individual Contribution	
Percentage	Dollar Amount
Family Contribution	
Percentage	Dollar Amount

Agreement and Understandings By signing below, you agree to the following:

1. The group named herein, which is duly organized under the laws of State of Nevada, hereby applies to Nevada Health CO-OP (NHC) for the benefits selected herein. The group understands and acknowledges that the actual benefits will be specified in the group contract if this application is accepted by NHC, and that benefits will take effect as of the date specified in such group contract. **This application is not a contract for healthcare benefits. Continue your current coverage until you are notified in writing that NHC has accepted this application.**
2. To be eligible for coverage, an individual must be an employee of the group or company applying for coverage. Any individual who applies for insurance coverage with NHC must be an employee, drawing a regular paycheck and with compensation reported on IRS Form W-2.
3. To be eligible for coverage by NHC, the group or company must be in compliance with all applicable laws of the State of Nevada.
4. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) or engaging in any fraudulent conduct, deception or misinterpretation relating to any application, coverage, claim or usage of an NHC identification card can result in denial of claim or rescission of coverage for the group or any group member, and may subject the group or any group to legal action by NHC.
5. Approval and acceptance of this Application and Individual Employee Application are subject to NHC guidelines.
6. It is agreed that this Application supersedes any previous applications for this group coverage.
7. By signing this Application, the authorized representative of the group or company represents that the group or company is not an entity that has been formed primarily to obtain health insurance coverage, and it does not permit membership in the group or company solely for the purpose of obtaining health insurance coverage.

Authorized Signature		
First Name	Last Name	Title
Authorized Signature		Date
Broker Name	Broker Signature:	
Agency:	Agency Code:	

Nevada Health CO-OP Approval:	
By:	Date:
Effective Date of Coverage:	GROUP NUMBER:

NOTE: Premium rates & policies are guaranteed for 12 months from the original effective date.