100 LILLIAN GISH BLVD.
P.O. BOX 4816
MASSILLON, OH 44648
PHONE: (330) 837-6880 • (800) 426-9013
FAX: (330) 837-6869

GROUPS OF 51 OR MORE ELIGIBLE EMPLOYEES

MUST BE COMPLETED BY EMPLOYER	HOMETOWN USE ONLY
Date of Hire:____/____/______ Group #___________________________________ Division #____________ Employer Signature:____	Effective Date:

YOUR PLAN CHOICE

Please list the HomeTown Plan you have selected:____

ABOUT YOU AND YOUR JOB

Employee Name (Last, First, M.I.):________________________________
Street Address:__________________________________ Apt:_______
City:____________________________ State:_______ ZIP:_________
Home Phone #:(___)____________ Work Phone #: (___)____________
Marital Status: ___Single ___Married ___Divorced ___Widowed
Date Married:___/___/_______ If divorced, does your former spouse have financial responsibility for any children? ___Yes ___No
List names of dependents for whom you have financial responsibility:
(1)____________________ (2)____________________(3)____________________
(4)____________________ (5)____________________

Employer: ____
Occupation/Job Title: ___________________________________
Business Phone #: ___________________________________
Full Time Date of Hire/Re-Hire: ___/___/_______
Employment Status: __Active __Retired __COBRA
COBRA Expiration Date: ___/___/_______

ABOUT YOU AND YOUR DEPENDENTS

	Name			Social Security Number	Date of Birth	Sex **M/F**	Primary Care Physician (First & Last Name) HMO & PPO Plans Only
	First	M.I.	Last				
Self							
Spouse							
1							
2							
3							
4							

If married in the last year, please list the maiden name of the employee or spouse as applicable:____________________

ABOUT YOUR OTHER HEALTH INSURANCE

If married, is your spouse employed? ___Yes ___No If yes, company name:____________________

Name of Policyholder	Name & Phone # of Other Insurance Co.	Policy Number	Effective Date	Type of Coverage	Work Status	Policy Type
			___/___/______	__Medical __Dental __Vision __Prescription	__Active __Retired	__Single __Family
			___/___/______	__Medical __Dental __Vision __Prescription	__Active __Retired	__Single __Family

Medicare Information:
Are you covered by Medicare? __Yes __No If yes, Medicare No.___________ Effective Dates: Part A___/___/_______ Part B___/___/_______
Is your spouse or dependent covered by Medicare? __Yes __No If yes, Medicare No. ___________ Effective Dates: Part A___/___/_______
Part B___/___/_______
Please attach a copy of your Medicare Card(s) if you answered yes to either question above.

WAIVER OF COVERAGE

__Yes __No – I waive health coverage through HomeTown for myself.
__Yes __No – I waive health coverage through HomeTown for the following dependents only:
1)____________________ 2)____________________ 3)____________________ 4)____________________ 5)____________________
I am waiving health coverage through HomeTown for the following reason:
__I have health coverage through my spouse's employer. (Please list under "About Your Other Health Insurance.")
__I have other health coverage. (Please list under "About Your Other Health Insurance.")
__I do not want health coverage at this time.

SPECIAL ENROLLMENT

If enrolling under Special Enrollment provisions please provide the following (applicable documentation may be required):
Type of Qualifying Event:____ Date of Qualifying Event:___/___/________

AUTHORIZATION

I have read and understand the terms.
Signature of Employee:____ Datet:___/___/________

Warning: Any person who, with intent to defraud or knowing that he or she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

CONDITIONS OF ENROLLMENT

I agree for myself and on behalf of my eligible dependents to the following conditions of enrollment in HOMETOWN HEALTH PLAN (HMO plans) or HOMETOWN INSURANCE GROUP, INC. (POS and PPO plans).

For individuals enrolling in a HOMETOWN INSURANCE GROUP, INC. benefit plan:

1. We will abide by the rules and regulations of HOMETOWN INSURANCE GROUP, INC.

2. We will be bound by the eligibility requirements, benefits, deductibles, copayments, coinsurance, exclusions, limitations and other terms of the HOMETOWN INSURANCE GROUP, INC. Master Group Policy and Certificate of Insurance.

3. We will complete and submit to HOMETOWN INSURANCE GROUP, INC. such consents, releases and other assignments as are reasonably necessary for HOMETOWN INSURANCE GROUP, INC., in accordance with its rights under the HOMETOWN INSURANCE GROUP, INC. Master Group Policy and Certificate of Insurance, to subrogate my or my dependents' rights, or to coordinate with other group health benefits plans or group insurance policies. I shall cooperate and assist HOMETOWN INSURANCE GROUP, INC. in the exercise of its subrogation and coordination of benefits rights.

4. We will make directly to the providers of health care such payments for copayments, coinsurance and deductibles as are required by the HOMETOWN INSURANCE GROUP, INC. Master Group Policy or Certificate of Insurance.

For individuals enrolling in a HOMETOWN HEALTH PLAN benefit plan:

1. We will abide by the rules and regulations of HOMETOWN HEALTH PLAN.

2. We will be bound by the eligibility requirements, benefits, deductibles, copayments, coinsurance, exclusions, limitations and other terms of the HOMETOWN HEALTHL PLAN Subscriptions Agreement and Certificate of Coverage.

3. With the exception of emergency procedures as defined in the HOMETOWH HEALTH PLAN Subscription Agreement and Certificate of Coverage, all services, in order to be covered by HOMETOWN HEALTH PLAN, must be performed either by a Participating Primary Care Physician or authorized by prior referral from a Participating Primary Care Physician in accordance with the policies and procedures of HOMETOWN HEALTH PLAN.

4. We will complete and submit to HOMETOWN HEALTH PLAN such consents, releases and other assignments as are reasonably necessary for HOMETOWN HEALTH PLAN, in accordance with its rights under the HOMETOWN HEALTH PLAN Subscription Agreement and Certificate of Coverage, to subrogate my or my dependents' rights, or to coordinate with other group health benefits plans or group insurance policies. I shall cooperate and assist HOMETOWN HEALTH PLAN in the exercise of its subrogation and coordination of benefits rights.

5. We will make directly to the providers of health care such payments for copayments, coinsurance and deductibles as are required by the HOMETOWN HEALTH PLAN Subscription Agreement or Certificate of Coverage.