



Employer Application for ARHealthNetworks Coverage

To enroll in the ARHealthNetworks Program:

- 1) Complete the following information and return to your insurance agent. **ALL fields are required.**
- 2) Attach appropriate documentation requested throughout this form.

Does your business qualify as a Group (two or more full-time employees) or are you Self-Employed?

Group Self-Employed

| ARHealthNetworks Guidelines For Group Coverage | | |
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| <ul style="list-style-type: none"> 100% of all eligible employees must enroll. At least 1 enrolled employee must have a household income =<200% of the federal poverty level. Only full-time (30+ hours/week) employees are eligible to participate. Employees must meet all other eligibility requirements. There is no waiting period at initial enrollment. New hired employee coverage begins the first of the month following 90 days from date of hire. | | |
| ARHealthNetworks Guidelines For Self-Employed Individuals | | |
| <ul style="list-style-type: none"> Gross household income must be =<200% of the federal poverty level. Self-employment must be supported by IRS documents proving legitimacy of the business. There is no waiting period at initial enrollment. Spouses can enroll as well, provided all eligibility guidelines are met. | | |
| Section I. Business Information | | |
| <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Non-Profit Organizations <input type="checkbox"/> Husband and Wife <input type="checkbox"/> Farm <input type="checkbox"/> Other _____ | | |
| <i>See provide proof of business documentation as listed in Section III.</i> | | |
| Company Tax ID#: | Requested Effective Date: | |
| Legal Name of Company(include dba): | Industry Type: | |
| Phone #: () | Fax #: () | Number of years in business: |
| Company Physical Address: | | City/State/Zip: |
| Company Contact Name | | Title: |
| Phone #: () | Fax #: () | Email: |
| Billing Contact Name: | | Phone #: () |
| Billing Address: | | City/State/Zip: |
| Is this company affiliated with any other company? If yes, company name: | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Section II. Broker Information | | |
| Name: | Phone #: () | Fax #: () |

Section III. Proof of Business Documentation

Businesses must provide one of the following applicable documents with the group application.

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| C Corporation | Form 1120 Form 941 Schedule E Payroll Ledger (if company has been in business less than 3 months) Articles of Incorporation/Organization (if company has been in business less than 3 months) Bylaws (if company has been in business less than 3 months) |
| S Corporation | Form 1120S Schedule K1 Form 941 (if there are employees, in addition to shareholders) Payroll Ledger (if company has been in business for less than 3 months) Articles of Incorporation/Organization (if company has been in business less than 3 months) Bylaws (if company has been in business less than 3 months) |
| Partnership | Form 1065 K-1's Payroll Ledger (if company has been in business for less than 3 months) Partnership Agreement Ledger (if company has been in business for less than 3 months) |
| Sole Proprietorship | Form 1040, including Schedule C Payroll Ledger (if company has been in business less than 3 months) Current Business License (if company has been in business less than 3 months) |
| LLC (Limited Liability Co.) | See "C Corporation" or "Partnership" or "S Corporation" |
| Acquisitions | Letter on company letterhead explaining situation Legal Transfer/Acquisition Documents SUTA from the acquired company Payroll Ledger |
| Non-Profit Organization | 941 W2's 990 (if gross receipts are over \$25,000 annually) Payroll Ledger |
| Husband and Wife Groups | See "C Corporation", "S Corporation", "Partnership", or "Sole Proprietorship" Must have legal documentation that both parties are receiving financial compensation from the employer. |
| Farm | 1040, including Schedule F Schedule F or 4835. If husband and wife, provide one (SCH F/4835) for each. If only one spouse is listed on the Schedule F, payroll is required for the other spouse. |
| Ranch | 1040, 943, and Schedule F |

Agreement and Signatures

- The employer has been informed of the eligibility requirements to obtain and maintain coverage under ARHealthNetworks for its employees. The employer agrees that coverage, even though applied for, shall not become effective or remain effective unless the employer a) is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and b) meets the participation and contribution requirements.
- The employer agrees that NovaSys Health has the right to audit any and all payroll records to ensure that all eligibility and enrollment requirements are met.
- The employer agrees that insurance applied for shall not become effective unless all applications, forms, and necessary documents are received, accepted, and approved by NovaSys Health and DHS. This includes documentation that the participants are citizens of the United States and/or residents of the State of

Arkansas for qualifications of eligibility requirements pertinent to additional funding assistance through ARHealthNetworks as indicated on the member application.

- The employer understands that there are no pre-existing condition restrictions for coverage through the ARHealthNetworks program. The employer acknowledges the limited nature of State Coverage Insurance and that the benefits of the ARHealthNetworks program are subject to regulatory changes. NovaSys Health will provide me with a 60-day advance notice of program changes, which affect my benefits or premiums.
- Premium payment will be monthly unless otherwise indicated. NovaSys Health will mail billing statements on or about the 15th of each month for the subsequent month of coverage. Premiums will be due by the 1st of the month in which coverage is effective.
- Your agent or broker cannot change or waive any provision of this application or the policy or policies pertaining to coverage under ARHealthNetworks without the written approval of an officer of NovaSys Health.
- The employer acknowledges and understands that if this application is approved, the summary plan document will determine all rights and benefits.
- The person signing this form for the employer has legal authority to bind the employer for whom application is being made.
- The employer agrees to make timely notification of any employee additions. The enrollment will be “timely” if the completed form is received by the Plan Administrator no later than 15 business days before the person becomes eligible.
- The employer agrees to make timely notification of any employee terminations. The disenrollment will be “timely” if the notification is received by the Plan Administrator no later than 5 business days after the Employer group receives notification of termination date.
- The employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the month in which premiums have been received. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The employer understands that coverage may also be terminated for other reasons as provided in the group policy. If the employer group is terminated for failure to pay their premium, the group will be disqualified from re-enrollment for 12 months following the termination.
- The employer agrees not to charge or pass along to any employee more than the billed premium associated with that employee.
- Any person, who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud. Fraud or misrepresentation may be grounds for nonrenewal or termination under the terms of the group policy. Under these circumstances, the decision to pursue and prosecute will be the decision of the State of Arkansas, Department of Human Services.

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| Employer (<i>company name</i>) | | |
| Signed by (<i>must be an officer</i>) | Officer’s title | Date signed |
| Licensed resident agent(s) (<i>individual/firm</i>) | Agent’s license number | Date signed |
| Signature of soliciting agent(s) (if more than one, all must sign.) | | Date signed |