



GROUP APPLICATION - INFORMATION DOCUMENT

This document will be requested to be reviewed annually at the health plan renewal period.

1 Full Legal Name of Employer Group (Contract Holder)

1a. Federal Tax ID Number 38-3856902 1b. IRS Section 125 [X] YES [] NO

2 Address

Physical Address 3663 Barron Way
City Reno State NV Zip 89511
Mailing Address (If different - Street or PO Box) Same
City Reno State NV Zip
2a. Telephone 775-326-6007 2b. Fax 775-328-3646 2c. Email carribillaga@tmfpd.us

3 Name / Title of Owner, General Manager or CEO

Name Richard Edwards Title Fire Chief
3a. Telephone 775-326-6000 3b. Fax 775-328-3646 3c. Email redwards@tmfpd.us

4 Company Billing Name and Address (If Different from Legal Name Noted Above)

Company Billing Name Same
Physical Address
City Reno State NV Zip 89511
Mailing Address (If different - Street or PO Box)
City Reno State NV Zip 89511
4a. Telephone 775-326-6007 4b. Fax 7753283646

5 Business Industry or Nature of Business Public Safety - Fire Protection District

6 NAICS Code (If available) 922190 6a. NAICS Description Other Justice, Public Order, and Safe

7 Company Type

[] Corporation [X] Political Subdivision
[] LLC [] S Corp.
[] Non-Profit [] Sole Proprietorship
[] Partnership [] Union
[] Other

8 Year Business Established

8a. Number of Employees (FT & PT) 189
8b. Number of Employees Eligible To Enroll 189
8c. Number of Employees Waiving Enrollment 0
8d. Please check appropriate box below to indicate your organization's size.*

[] Less than 20 full- or part-time employees**
[] 20 to 99 full- or part-time employees**
[X] 100 or more full- or part-time employees**

*Mandatory Insurer Reporting Law-Section 111 of Public Law 110-173
**If organization is part of a multi-employer plan (a group of plans), please count employees in other groups/plans also.

9 Did Your Company Currently Offer Health Insurance?

9a. If Yes, please list the carrier information below

9b. Does your company offer other insurance options? (e.g. Dental and/or Vision)

[X] YES [] NO

If Yes, please list below
Coverage Type Dental and Vision
Carrier Name MetLife

10 Employer Contribution to Employee and Dependent Premium

Enter the Percentage or Dollar Amount; Minimum is 50% of Employee Premium
Hourly Salaried Other (Please specify) 4 levels ER pd retirees
EE 100 EE 100 EE Retiree 100% Retiree 80% Retiree 60% Retiree 50%
DEP 50 DEP 50 DEP 50 DEP 0% DEP 0% DEP 0% DEP 0%



GROUP INFORMATION

A COMPANY INFORMATION

1a. Company Name Truckee Meadows Fire Protection District

B COMPANY BENEFIT ADMINISTRATOR(S)

1b. Corporate Contact

Last Name Arribillaga First Name Carla Middle Initial
Title Human Resources Manager
Address 3663 Barron Way
City Reno State NV Zip 89511
Telephone 775-326-6007 Extension Fax 775-328-3646 Email carribillaga@tmfpd.us
Receives Contract / Renewal Notices Receives Hometown Health Employer Newsletter

2b. Local Contact (If Same as Corporate Contact, Leave Blank)

Last Name Same First Name Middle Initial
Title
Address
City State Zip
Telephone Extension Fax Email
Receives Contract / Renewal Notices Receives Hometown Health Employer Newsletter

3b. Premium Billing Contact (If Different than Contacts Listed Above)

Last Name Pahalke First Name Kimberly Middle Initial
Address 3663 Barron Way
City Reno State NV Zip 89511
Telephone 775-326-6072 Extension Fax Email tmfpd-ap@tmfpd.us

4b. Other Company Contacts (If Applicable)

Last Name Hagan First Name Rochelle Middle Initial
Address 3663 Barron Way
City Reno State NV Zip 89511
Telephone 775-326-6082 Extension Fax 775-328-3646 Email tmfpdhr@tmfpd.us

C GROUP PLAN SELECTION

1c. Number of Plans Selected by Employers - Hometown Health allows Small Employers to select up to two (2) plans for less than five enrolled employers and up to three (3) plans for five or more enrolled employees. There is no restriction of metal levels offered.

HMO EPO PPO Vision
Plan Elected Plan Elected Plan Elected Plan Elected
PPO HDHP HSA 5000
PPO 500
Non-National & National both



GROUP ELIGIBILITY AND PAYMENT PROVISIONS

Please return with renewal/new packet.

A Company Name Truckee Meadows Fire Protection District Group Size 185

Check categories in each Provisions Section: **B – Eligibility Status** and **C – Commencement of Coverage**

B ELIGIBILITY STATUS (Check All Categories Applicable)

Salaried	Hourly	Other (Please List)	1b. Eligible Employees:	
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Fire Chief Day 1	<input checked="" type="checkbox"/> Active Employees	<input checked="" type="checkbox"/> Retirees
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> All other Day 31	<input checked="" type="checkbox"/> Permanent Full Time Employees*	<input checked="" type="checkbox"/> Leave of Absence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (Attach Explanation)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Eligible employee means a permanent employee who has a regular working week of 30 or more hours.../NRS689C.065	

2b. Dependent Policy

- Employee Only (available for Employers with fewer than 50 full-time equivalent Employees)
- Employees and dependent children
- Employees, spouse and dependent children
- Employees, spouses, domestic partners and dependent children

C COMMENCEMENT OF COVERAGE (Check All Categories Applicable)

ELIGIBLE EMPLOYMENT BEGINS ON

- Date of Hire (Default)
- OR
- Following a reasonable and bona fide employment-based orientation period of 30 days (not to exceed 30 days).
By selecting this box you attest that the orientation period you require is both reasonable and bona fide.
Eligible employment also begins when a part time employee begins to work full time.

Salaried	Hourly	Other (Please List)	1c. Newly Eligible Employees Effective For Coverage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fire Chief Day 1 commences	<input type="checkbox"/> 1st of Month on or following date of eligible employment <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1st of the Month on or following _____ day(s) of eligible employment (60 days max) <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1st of Month on or following 1 month of eligible employment <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Additional Information (Attach Explanation) <i>Termination of Coverage =</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LARGE EMPLOYERS ONLY HAVE THE FOLLOWING ADDITIONAL OPTIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Date of eligible employment <i>Termination of Coverage = Midnight, the date of termination</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> 31 _____ days OR _____ months from date of eligible employment (90 days max) <i>Termination of Coverage = Midnight, the date of termination</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (Attach Explanation) <i>Termination of Coverage = Last day of month which employee ceases to be eligible</i>

2c. Newly Eligible Dependents – Births and Loss of Coverage Will Always be Date of Event

- 1st of Month following Date of Eligibility/Event
- Date of Eligibility/Event
- Other (If other, explain below)



C COMMENCEMENT OF COVERAGE (Continued)

If this section is not addressed, policy will default to Newly Eligible Employee Provision

If this section is not addressed, policy will default to Newly Eligible Employee Provision - only applies to employees covered prior to termination with current carrier.

3c. Part Time to Full Time Policy

Only applies to large groups

Does Not Apply
Minimum Number of Days OR Months

WORKING P/T BEFORE GOING F/T, THEN COVERAGE EFFECTIVE

Date of Full Time Status
 1st of Month following Full Time Status
 Other (Attach Explanation)

4c. Rehire Employee Policy

Does Not Apply
OR If Rehired within Days OR Months of Termination then is Coverage Effective

Date of Rehire (Only applies to large groups)
 1st of Month following Rehire
 Other (Attach Explanation)

Maximum period for rehire policy is 12 months

D PAYMENT PROVISIONS

Full Monthly Premium	
IF COMMENCEMENT OF COVERAGE FALLS ON	The 1st through the 15th of the month - FULL PREMIUM DUE The 16th through the end the month - NO PREMIUM DUE
IF TERMINATION OF COVERAGE FALLS ON	The 1st through the 14th of the month - NO PREMIUM DUE The 15th through the end the month - FULL PREMIUM DUE

Updates and revisions to these provisions can ONLY be made at renewal date of health plan(s) and must be approved by carrier. All Changes must be submitted in writing.

Authorized signature required below for approval of current provisions or changes made.

Print Name Carla Arribillaga Date _____

Print Title of Company Representative Human Resources Manager

Signature of Company Representative Carla Arribillaga Digitally signed by Carla Arribillaga Date: 2025.11.03 11:37:38 -08'00'

Primary Contact Carla Arribillaga Email Address carrbillaga@tmfpd.us

Secondary Contact Rochelle Hagan Email Address rhagan@tmfpd.us

Notes _____

AREA FOR HOMETOWN HEALTH USE ONLY

Renewal Effective Date _____
Date _____ SSR _____ Section Changed _____ Effective Date 1/1/2026



EMPLOYERS STATEMENT

Company Name Truckee Meadows Fire Protection District

- 1 I wish to enroll the above named company as a group account with:
 - Hometown Health Plan (HMO) Hometown Health Plan (EPO)
 - Hometown Health Providers Insurance Co. (PPO)
- 2 I understand and agree to abide by the eligibility rules applicable to employee enrollment as provided in the Evidence of Coverage (EOC).
- 3 I understand the participating requirements for specific coverage(s) and that those requirements must be met and maintained in order for the group to remain eligible for coverage.
- 4 I understand and agree to abide by the following prepayment requirement: Monthly prepayment fees are due and payable, in full, by the first day of the calendar month for which services are provided. Premium is delinquent if not received by the 15th of the month. Coverage will terminate on the last day of the month retroactive to the month for which payment is not received. Any other payment arrangements require our prior approval.
- 5 The group herewith tenders \$ ⁰ and, in consideration of approval of the application, promises to pay any balance necessary to constitute the full initial payment for group benefits herein identified. It is understood that we have the right to accept or reject application. Coverage will not commence until the application has been accepted.
- 6 I understand that the Group Subscription Agreement (GSA) that includes the EOC, provides specific guidelines for administration of coverage.
- 7 The Group appoints the following Company / Agency as Producer of Record:
 - Print Company / Agency LP Insurance Services, LLC
 - Print Producer Name LLoyd Barnes, Founding Principal / Sales Executive & Samm Petersen, Employee Benefits Account Mgr
- 8 To the best of our knowledge and belief, the information provided by the group is true and, along with the group application, is the basis for issuance of coverage and will become a part of the GSA.

Print Name Alexis Hill Date _____

Print Title of Company Representative Board of Fire Commissioners, Chair

Signature of Company Representative _____