HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Individual Applicant Enrollment Form

I am (We are) requesting my (our) application be effective the first day of the month of:_____

Type of application (check one)

☐ Annual Open Enrollment (11/01/17 – 12/15/17)
☐ Outside of Open Enrollment (No Qualifying Life Event)
Effective date is first of the month following 90 days after receipt of application

☐ Qualifying Life Event Date of Event____/____/____
Type of Event:
☐ Birth or Adoption ☐ Marriage / Divorce
☐ Loss of Coverage ☐ Other_____

I understand I must provide a physical address for application purposes. Additionally, if I make any intentional misrepresentations of material fact, Health Plan of Nevada/Sierra Health and Life has the right to rescind coverage and declare coverage under the Plan null and void as of the original Effective Date of coverage and refund any applicable premium. An application without a physical address will be returned to me and my requested effective date may be changed as a result.

Signature_____ **Date**_____

STEP 01 Plan selection (please provide all responses in ink)

Select medical plan by checking the box

Health Plan of Nevada, Inc. (HPN) MyHPN Solutions (Clark/Nye/Washoe County residents only)		**Sierra Health and Life Insurance Company, Inc. (SHL) MySHL Solutions (Clark County residents only)**		
Bronze HMO ☐ 7 ☐ 10 ☐ 11 ☐ 12	2 Tier Bronze HMO ☐ 1	Bronze EPO ☐ 7 ☐ 9	Silver EPO ☐ 1 ☐ 2 ☐ 6 ☐ 8.1	
Silver HMO ☐ 1.1 ☐ 3.1 ☐ 7 ☐ 8 ☐ 9	2 Tier Silver HMO ☐ 1 ☐ 2	Gold EPO ☐ 7	Silver HSA EPO ☐ 1.1	
Gold HMO ☐ 7		Bronze HSA EPO ☐ 2.1 ☐ 3.1	Catastrophic EPO ☐ 1	Catastrophic PPO ☐ 1

Optional products (additional premium applies)

☐ HPN Adult Vision Rider (age 19+)	☐ SHL Adult Vision Rider (age 19+)
☐ DHMO (family coverage for all enrollees) ☐ SHL Adult Dental PPO Plan (age 19+)	☐ SHL Adult Dental PPO Plan (age 19+)

STEP 02 Applicant information (please write clearly)

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner (DP)

Coverage type: ☐ Myself ☐ Myself & Spouse ☐ Myself & Child(ren) ☐ Child Only ☐ Family

Last name	First name	MI

Physical address (street – **not** PO Box)	Apt#	City, State	ZIP
Mailing/Billing address (if different from above)	Apt#	City, State	ZIP

Home phone	Cell phone
– –	– –

Email

Emergency contact name Phone – –

If this is a Child Only Application – Complete the information below:

Parent/Legal Guardian as responsible party - print full name Phone – –

Agency/Agent information – Must be complete to receive commissions

NPN or Commission Entity ID_____

Agency name_____ Agent name_____

Sales Rep_____ Effective Date_____

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STEP 03 Applicant and Eligible Family Member information

Please list yourself and all Eligible Family Members applying for or changing coverage. Only your spouse/domestic partner and/or Eligible Children (up to age 26) may apply as Dependents.

This section must be completed for new Applicants and when adding an Eligible Family Member

	Member information					HPN Options Only	
Applicant	Last name	First name	MI	Date of birth / /		Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females)
	Social security # (age 5+) - -	Valid Nevada ID # (age 19+)		Gender ☐ M ☐ F			
	Other coverage: If yes, carrier name and effective date		Medicare A/B eligible ☐ Y ☐ N	Tobacco use[1] ☐ Y ☐ N			
Spouse/D.Partner	Last name	First name	MI	Date of birth / /		Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females)
	Social security # (age 5+) - -	Valid Nevada ID # (age 19+)		Gender ☐ M ☐ F			
	Other coverage: If yes, carrier name and effective date		Medicare A/B eligible ☐ Y ☐ N	Tobacco use[1] ☐ Y ☐ N			
Child 1	Last name	First name	MI	Date of birth / /		Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females)
	Social security # (age 5+) - -	Valid Nevada ID # (age 19+)		Gender ☐ M ☐ F			
	Other coverage: If yes, carrier name and effective date		Medicare A/B eligible ☐ Y ☐ N	Tobacco use[1] ☐ Y ☐ N			
Child 2	Last name	First name	MI	Date of birth / /		Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females)
	Social security # (age 5+) - -	Valid Nevada ID # (age 19+)		Gender ☐ M ☐ F			
	Other coverage: If yes, carrier name and effective date		Medicare A/B eligible ☐ Y ☐ N	Tobacco use[1] ☐ Y ☐ N			
Child 3	Last name	First name	MI	Date of birth / /		Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females)
	Social security # (age 5+) - -	Valid Nevada ID # (age 19+)		Gender ☐ M ☐ F			
	Other coverage: If yes, carrier name and effective date		Medicare A/B eligible ☐ Y ☐ N	Tobacco use[1] ☐ Y ☐ N			
Child 4	Last name	First name	MI	Date of birth / /		Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females)
	Social security # (age 5+) - -	Valid Nevada ID # (age 19+)		Gender ☐ M ☐ F			
	Other coverage: If yes, carrier name and effective date		Medicare A/B eligible ☐ Y ☐ N	Tobacco use[1] ☐ Y ☐ N			
Child 5	Last name	First name	MI	Date of birth / /		Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females)
	Social security # (age 5+) - -	Valid Nevada ID # (age 19+)		Gender ☐ M ☐ F			
	Other coverage: If yes, carrier name and effective date		Medicare A/B eligible ☐ Y ☐ N	Tobacco use[1] ☐ Y ☐ N			

[1]Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)?

[2]If enrolling in a Health Plan of Nevada plan, select a Primary Care Providers (PCP) or Pediatrician from the Health Plan of Nevada provider directory available at myHPNonline.com. Females should also select an OB/GYN physician.

STEP 04 Acknowledgements and application completion - SIGNATURE REQUIRED

By signing this document:

1. I, we, or legally Authorized Representative (Brokers, Producer, Agent, etc.) on behalf of client, (hereinafter referred to as Applicant) hereby apply to Health Plan of Nevada/Sierra Health and Life for coverage now being offered to the Eligible persons in this application. Applicant understands that this application for coverage is subject to acceptance by Health Plan of Nevada/Sierra Health and Life and that is an Agreement is issued, service will be available subject to the terms, exclusions, limitations and benefits described in the Health Plan of Nevada/Sierra Health and Life Agreement of Coverage (AOC) and the applicable Attachment A Benefit Schedule and any applicable Endorsements, Riders and Attachments thereto.
2. **Applicant attests they are not eligible and/or enrolled in Medicare Part A and/or Part B at the time of this application.**
3. Applicant understands they are entitled to a copy of this form.
4. Applicant understands if they are not satisfied for any reason or if the premium rates are not acceptable, within ten (10) days of receiving the AOC, they may return the AOC materials and request a full refund of the premium paid, less any claims paid, if applicable.
5. Applicant understands that if they are applying for individual coverage outside the annual Open Enrollment period, upon approval of this application, Applicant is subject to a waiting period of ninety (90) days after the date on which the application for coverage was received and coverage becomes effective upon the first day of the month immediately following the date in which the waiting period expires. Applicant understands that the policy is not retroactive to the date on which the application was received.
6. Applicant understands that the payment submitted with this application will be processed at the time of approval and policy issuance.

Applicant represents that all statements and answers in this application are true and complete to the best of their knowledge. Applicant agrees that this shall be the basis of the acceptance of membership. Applicant understands when information provided to Health Plan of Nevada/Sierra Health and Life in this application is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage, Health Plan of Nevada/Sierra Health and Life shall have the right to retroactively adjust past premium payments to the maximum rate allowed that would have been billed if such untrue, inaccurate, or incomplete information had properly been provided. If the revised premium rate is not received by Health Plan of Nevada/Sierra Health and Life within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to-date.

Applicant understands that Nevada requires specific authorization from the applicant agreeing to arbitration. If Applicant is dissatisfied with the findings of an Independent Medical Review, Applicant shall have the right to have the dispute submitted to binding arbitration before an arbiter under the commercial arbitration rules applied by the American Arbitration Association.

Signature_____ Date_____

If an Authorized Representative is completely this application on behalf of a client, the Authorized Representative understands and hereby attests that they have written authorization from his/her client to apply for health insurance coverage on behalf of his/her client. The Authorized Representative further attests that such written documentation will be made available to Health Plan of Nevada/Sierra Health and Life upon request.

APPLICANT OR COURT APPOINTMENT LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ON BEHALF OF APPLICANT:

Signature_____ Date_____

WARNING: If is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

Signature_____ Date_____

I acknowledge that the information provided in this application is true and that:

Initials_____ **I am a resident of Nevada and reside in the service area of which I have applied for coverage**

Initials_____ **I will notify HPN/SHL if a third party will be paying my premiums at any time in the future, after my coverage is effective, AND I acknowledge HPN/SHL does not accept payment from third parties except for the following:**
- **Ryan White**
- **State/Local Government**

Initials_____ **I attest that I am not eligible and/or enrolled in Medicare Part A and/or Part B at the time of this application.**

Initials_____ **I may be required to provide proof of residency.**

Initials_____ **I attest that no non-licensed third party (e.g., medical facility) assisted me in the completion of this application.**

Initials_____ **I am electing to receive all future notices and/or documents from HPN/SHL in electronic format.**

Initials_____ **I am declining to receive all future notices and/or documents from HPN/SHL in electronic format. I understand I may change my delivery preferences at any time.**
Set your delivery preferences. Opt-in to receive information electronically, request paper documents or update your information. Visit myHPNonline.com or mySHLonline.com and sign in. First-time users will need to create an account using their member ID.

Premium payment options

In order to enroll through Health Plan of Nevada/Sierra Health and Life, you are required to make an initial premium payment at the time of application submission.

PLEASE PRINT CLEARLY

Applicant/Member Last name	First name	MI

Applicant/Member email address	Phone
	– –

Is a third party providing funds to pay the premiums for your insurance coverage? ☐ Yes ☐ No
If yes, please identify the third party providing funds (directly/indirectly) to pay the premiums:

_____

I will pay with the following payment option:

☐ Credit/Debit card ☐ EFT/ACH bank draft ☐ Check or money order

If choosing to pay by **credit/debit card**, you must complete **all** of the following information:

Cardholder name as it appears on card			
Cardholder billing address	City	State	ZIP
Credit card #	Exp date (MM/YY)	CVV/CVC	

– – – OR – – –

If choosing to pay by **EFT/ACH bank draft**, you must complete **all** of the following information:

Bank account holder name as it appears on bank statement	Type of account ☐ Checking ☐ Savings
Routing #	Bank account #

Amount to charge upon application submission $_____

☐ ***Initial Payment Only*** I authorize Health Plan of Nevada/Sierra Health and Life to charge my credit/debit OR debit my bank account for the payment amount shown above at the time my Application is submitted. I understand the amount authorized will be charged in its entirety upon approval of this Application and may or may not be my final monthly premium. **I am responsible for any premium due on my account. Any credits will be applied to future billings.**

☐ ***Initial and Recurring Monthly Payments*** I authorize Health Plan of Nevada/Sierra Health and Life to charge my credit/debit card OR debit my bank account equal to the monthly billed premium and/or any past due premiums for this Individual Plan from Health Plan of Nevada/Sierra Health and Life.

The monthly premium will be automatically charged to the credit/debit card or debited from the bank account indicated above on the 10th day of the month (or next business day if a weekend or holiday) for which the premium is due. **This authorization is to remain in full force and effect until Health of Nevada/Sierra Health and Life have received written notification of its termination** in such a manner as to afford Health Plan of Nevada/Sierra Health and Life and the financial institution a reasonable opportunity to act on it. **In the event your monthly premiums increase, the increased premium rate will be deducted from your account.**

Card/Account holder signature_____ Date_____