Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

2026 Individual Change Form

For use with Off Exchange policies only. Contact Nevada Health Link for On Exchange policies.
ALL PAGES OF THIS FORM MUST BE SUBMITTED.

Section 1: <u>All information must be completed by subscriber</u>			
Subscriber First Name *(required)*	Subscriber Last Name *(required)*	MI *(optional)*	Requested Effective Date * *(required)*
Subscriber Member ID *(required)*	Subscriber DOB *(optional)*	Subscriber SSN *(optional)*	

Type of change (check the boxes that apply and complete only the appropriate sections)

- ☐ Personal Information (Section 2)
- ☐ Change Coverage (Section 3)
- ☐ Ancillary Coverage (Section 4)
- ☐ Dependents (Section 5) (circle one): Add - Remove
- ☐ Tobacco Attestation (Section 6)
- ☐ Broker of Record Change (Section 7)
- ☐ Termination/Request for New Policy for Dependents (Section 8)
- ☐ Other (Explanation):
- ☐ Update Responsible Party for a Child Only policy (Section 9)
- ☐ Termination (Section 10)

Email Address for paperless communications: _____

By providing your email address, you agree, 1) to be automatically enrolled in paperless delivery for some of your plan communications, and 2) you have reviewed the Required Plan Communications Notice[3]. You also agree to receive Required Plan Communications electronically.
You will get many of your required plan communications delivered electronically. We will send you an email when new communications (such as: benefit and plan information, claims, billing and payments, regulatory notices and tax documents) are available online.
If you would rather have hard copies of required materials mailed to you, please check here:
☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time by signing in to the online member center.

Section 2: Personal Information		
New Name (please attach legal documentation, i.e., Marriage License, Driver's License)		
Current Name:	New Name:	
New Address/Phone/Email		
Street:	Apt #:	Phone:
City:	State:	ZIP:
Email Address:	Social Security #:	Valid Nevada Driver's License / ID Number:

Race (Please choose one option below)		**Ethnicity** (Please choose one option below)	**Preferred Spoken and Written Language** (Please choose one option below)
☐ Two or More Races	☐ Native Hawaiian or Other	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ Pacific Islander	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ White	☐ Declined	☐ Declined
☐ Black or African American	☐ Declined		
☐ Middle Eastern	☐ Other		

Section 3: To Change Coverage ☐Open Enrollment (11/1/25 to 1/15/26 only) ☐First of month following 90 day wait			
Health Plan of Nevada: MyHPN Solutions HMO		Sierra Health and Life: MySHL Solutions EPO	
Bronze HMO	☐1 ☐2	Bronze EPO	☐11 ☐12 ☐13 ☐14
Bronze HMO Plus	☐3 ☐4	Silver EPO	☐1 ☐2 ☐6 ☐7 ☐8 ☐9
		Gold EPO	☐7
Silver HMO	☐1.1 ☐3.1 ☐4	Bronze HSA EPO	☐3.1
Gold HMO	☐7	Catastrophic EPO	☐ (available under age 30)

Section 4: Optional Ancillary Coverage[1] (additional premium applies)
(must be enrolled in an off exchange medical plan in order to add ancillary dental and/or vision) (All adults 19+ on the same policy will be covered when the ancillary plan is selected)

Type of change (check the boxes that apply)

Dental:

☐ Add PPO Adult Dental (ages 19+)
☐ Add Exclusive Network Dental Plan S800B (all new members)
☐ Remove Dental

Adult Vision (ages 19+):

☐ Add Coverage
☐ Remove Coverage

Section 5: Addition/Removal of dependents (NOTE: Use additional sheet if necessary)

(check the box that applies) ☐ **Addition** of dependents (attach supporting QLE documentation) ☐ **Removal** of dependents

	First Name	Last Name	MI	DOB	Gender M / F	SSN (age 5+)
Spouse						

Valid NV DL/ID # (age 19+)	Tobacco use[2] Y N	PCP Code	OB/Gyn code

Race (Please choose one option below)		Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
☐ Two or More Races	☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ White	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Middle Eastern			

ICHRA (Individual Coverage Health Reimbursement Arrangement): ☐ Yes ☐ No ☐ Unknown

QSEHRA (Qualified Small Employer Health Reimbursement Arrangement): ☐Yes ☐No ☐Unknown

If Yes, check applicable boxes

QSEHRA Plan Premium

☐ Subscriber QSEHRA used for Plan Premium
☐ Spousal QSEHRA used For Plan Premium
☐ Not Applicable ☐ Unknown

QSEHRA Medical/Rx Claims

☐ Subscriber QSEHRA used for medical and/or Rx claim reimbursement
☐ Spousal QSEHRA used for medical and/or Rx claim reimbursement
☐ Subscriber and Spousal QSEHRA used for medical and/or Rx claim reimbursement
☐ Not Applicable ☐ Unknown

	First Name	Last Name	MI	DOB	Gender M / F	SSN (age 5+)
Child						

Valid NV DL/ID # (age 19+)	Tobacco use[2] Y N	PCP Code	OB/Gyn code

Race (Please choose one option below)		Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
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☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Middle Eastern			

	First Name	Last Name	MI	DOB	Gender M / F	SSN (age 5+)
Child						

Valid NV DL/ID # (age 19+)	Tobacco use[2] Y N	PCP Code	OB/Gyn code

Race (Please choose one option below)		Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
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☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Middle Eastern			

Explanation For Change - You must attach documentation to add dependent(s).

☐ Newborn date _____ ☐ Adoption date _____ ☐ Marriage date _____

☐ Date of Loss of coverage _____ ☐ Other _____

Section 6: Tobacco Attestation

If you originally enrolled as a tobacco user and have been tobacco free for at least six months, check here. ☐

If you originally enrolled as a non-tobacco user and have recently started using tobacco products, check here. ☐

Upon submission of this attestation, your premium will be adjusted to reflect the tobacco or non-tobacco rate effective the first day of the following month in which we receive this completed change form.

Section 7: Broker of Record Change Request

New Agency: _____ Incumbent Agency: _____

Section 8: Termination/Request for New Policy for Dependents

I am requesting termination of my policy effective _____ date. Any automatic EFT payments will stop.

I request that my dependent(s) be established on their own policy effective _____ date.

I understand the following:

1. That my policy will be terminated and that my dependent(s) will have a new policy, with a new Member ID number on the first of the month following my termination.
2. The new policy will be for the same plan.
3. Once the new Member ID is established, my dependent(s) will need to set up new automatic EFT payments, if desired.

Section 9: Update Responsible Party for a Child Only policy

Parent/Legal Guardian as responsible party - print full name

First name	Last name	Phone

Section 10: Termination

Completion of this section will terminate coverage for subscriber and all dependents. **Coverage is in effect through midnight of the last day of the month in which the termination request is received.**

Requested Termination Date: _____ Reason For Termination: _____

Section 11: Signature (required)

NOTE: HPN/SHL reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber 30 days notice prior to the Annual Open Enrollment as established by Federal Guidelines. Any such adjustment will apply to all member/insureds in the same class.

I hereby apply to HPN/SHL for a change in coverage now being offered to my eligible family member(s) and me. I understand this application is subject to acceptance by HPN/SHL and if an agreement is issued, services will be available subject to the terms, exclusions, limitations and benefits described in the agreement of coverage, Attachment A Benefit Schedule and any applicable endorsements, riders and attachments thereto.

Subscriber/guardian signature: _____ **Date:** _____

Warning: It 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.

[1] One mid-year change from one dental product to another is allowed. Members who terminate dental and/or vision mid-year will not be allowed to re-elect until the following open enrollment period. Ancillary changes are effective on the first day of the month following receipt of completed change form.

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

[3] Certain laws require that we give specific information to you in writing. We may send Required Plan Communications electronically when you give us permission. Not all Communications require permission before sending. This Notice only applies when permission is required. You may change your mind at any time, and we will send paper communications to you. These Communications may include: Plan documents and legal notices; Benefit decisions, such as Explanation of Benefits; and Privacy notices. Communications are based on the Plan you have. You will get new communications as they become electronic. If there is not an electronic version, we will send by mail.

How will Communications be sent? We will send you an email when a document is ready to view online.

What if my email changes? Update your email right away. It is your responsibility to give us correct information. Communications may be delayed if we have the wrong information. If this happens, you hold us harmless.

What happens if I change plans? If you change or add a benefit plan, program, product or service, we may use the same contact information you provided before.

Can I go back to mail? Yes, you may change your mind at any time. You may change your choice by going to your member website or mobile application or call the member number on your ID card. Paperless delivery will stay until you change your choice to mail. Changes may take up to seven business days to process.

Can I get a paper copy? Yes, you have the right to a free paper copy. You may print a copy on your member website or call the member number on your ID card and we will mail it to you.

Hardware and software requirements In order to get, view, and keep these Communications you must have, at your own cost, the following: Internet or Mobile access; Registration on member website; An email account with software; and Acrobat Reader or similar software to view PDF files.

[a]We means United HealthCare Services, Inc. and/or Optum, Inc. and/or their affiliated companies