

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly.

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: Sierra Health and Life

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



**SIERRA HEALTH AND LIFE
INSURANCE COMPANY, INC.®**
a subsidiary of Sierra Health Services, Inc.®

Follow these simple instructions below:

- 1. Please detach and complete sections 1 through 9 of the individual Applicant Enrollment Form provided in this booklet.** Make sure that all information provided is complete and accurate. Be sure to indicate which plan you wish to enroll in, then sign and date each form.
- 2. Print clearly** using blue or black ink.
- 3. Enclose a Visa or MasterCard authorization or a check** made payable to Health Plan of Nevada or Sierra Health and Life (depending on the plan you choose) with the appropriate premium for the plan you select. You have the option of making a monthly payment directly to Health Plan of Nevada or Sierra Health and Life by having your monthly payment deducted from your checking account with the SurePay option. If you elect the SurePay option, complete and sign the enclosed Pre-Arranged Payment Authorization Agreement, and enclose a voided check. If you elect the direct billing option where you receive a monthly bill, you will be charged a \$10 fee each month.
- 4. Return the Individual Applicant Enrollment Form and, if applicable, the Electronic Funds Transfer (EFT) Form (section 5) along with your payment** to Health Plan of Nevada or Sierra Health and Life in the enclosed, self-addressed envelope.
- 5. Our Medical Underwriting Department** will contact you by phone as part of the enrollment process. This telephone interview must be completed before coverage can be approved.



Once your application is approved, we will forward your Plan documents, membership card and other important information to you. You will also receive written confirmation of approval and the effective date of your coverage.

If for any reason you are not satisfied with the policy after examining it for 10 days, you may return the policy for a full refund.

If we are not able to approve your application, you will receive written notice of declination.

Most common causes for a delay in processing

- ✓ Missing or incomplete personal information such as: weight, height, spouse's social security number, age and date of birth.
- ✓ Incomplete information such as mailing address, telephone numbers, etc.
- ✓ Incomplete answers. If the question does not apply to you, please reply with N/A. Do not leave any answers blank.
- ✓ The application is not signed by all listed dependents over age 18.
- ✓ No response to telephone interview.
- ✓ Oldest person is not listed as primary subscriber.
- ✓ Altered applications.



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

For internal use only: Accepted Declined Effective Date ___/___/___ Date Processed ___/___/___ UW _____

Billing Option: Direct Bill (Additional \$10 processing fee/month) Electronic Funds Transfer (EFT)

PLEASE PROVIDE ALL RESPONSES IN BLACK INK

Section 1. Plan Selection and Requested Effective Date

Please mark your medical product selection: Health Plan of Nevada, Inc. (HPN) or Sierra Health and Life Insurance Company, Inc. (SHL)

HPN HMO Distinct Advantage (No Maternity-Options 2 & 4)	SHL PPO Distinct Advantage (No Maternity Coverage)	SHL HSA Sierra Simplicity (No Maternity Coverage)	HIPAA Guarantee Issue ¹ (Basic = No Maternity Coverage)
<input type="checkbox"/> Option 1*	<input type="checkbox"/> Plan 1 – 1000	<input type="checkbox"/> Plan A – 1500	<input type="checkbox"/> PPO Standard HIPAA
<input type="checkbox"/> Option 2	<input type="checkbox"/> Plan 2 – 1500	<input type="checkbox"/> Plan B – 2500	<input type="checkbox"/> Optional Standard Autism Rider
<input type="checkbox"/> Option 3* (POS)	<input type="checkbox"/> Plan 3 – 2500	<input type="checkbox"/> Plan C – 2500	<input type="checkbox"/> PPO Basic HIPAA
<input type="checkbox"/> Option 4	<input type="checkbox"/> Plan 4 – 5000	<input type="checkbox"/> Plan D – 5000	
<input type="checkbox"/> Optional HMO Dental	<input type="checkbox"/> Plan 5 – 7500	<input type="checkbox"/> Optional Autism Rider	<input type="checkbox"/> HMO Standard HIPAA
<input type="checkbox"/> Optional Autism Rider	<input type="checkbox"/> Plan 6 – 10000		<input type="checkbox"/> Optional Standard Autism Rider
	<input type="checkbox"/> Optional Autism Rider		<input type="checkbox"/> HMO Basic HIPAA
			<input type="checkbox"/> Optional HMO Dental

*12-month Maternity Waiting Period applies

¹See page 9, #10

If HPN/SHL approves my application, please request an Effective Date of Coverage of:

1st of (month) _____ 15th of (month) _____ (See pages 2&3 for further details)

Section 2. Applicant Information

Marital Status: ___ Single ___ Married* ___ Divorced ___ Widowed ___ Domestic Partner (DP)*

*If last names are different, must supply marriage certificate or proof of domestic partnership

First Name: _____ MI: _____ Last Name: _____

Street Address: _____

Street

Apt #

City

State/Zip

Billing Address: (If different than above) _____

Email Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Business Phone (_____) _____

Occupation/Title: _____

Emergency Contact Name: _____ Phone Number (_____) _____

Agent Information – Must be completed to receive commissions

Entity or Tax ID # _____ Office Phone #: _____ Cell Phone # _____

Agent/Agency Name: _____ Agent's Signature _____

Street Address: _____ City/State/Zip: _____

INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

Section 3. Applicant and Eligible Family Member Information. Please list yourself and all Eligible Family Members applying for or changing coverage. Only your spouse/DP and Eligible Family Member(s) up to age 26 may apply as Dependents. For “Family” and “Subscriber and Spouse/DP” policies, the primary Applicant must be the older spouse/DP. Please list Applicants in the following order as applicable: 1st Primary Applicant (older spouse/DP), 2nd Spouse/DP, 3rd Child(ren).

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

HPN Options Only

	Full Name	Social Security Number	Birth Date MM/DD/YY	Gender	Primary Care Provider (PCP) ¹ or Pediatrician	OB/GYN (For Females)	Optional Autism (ASD) Coverage ²
1.	Applicant			<input type="checkbox"/> M <input type="checkbox"/> F			
2.	Spouse/DP			<input type="checkbox"/> M <input type="checkbox"/> F			
3.	Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Accept <input type="checkbox"/> Decline
4.	Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Accept <input type="checkbox"/> Decline
5.	Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Accept <input type="checkbox"/> Decline
6.	Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Accept <input type="checkbox"/> Decline
7.	Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Accept <input type="checkbox"/> Decline

1. If enrolling in an HPN Plan, select a Primary Care Physician (PCP) or Pediatrician from the HPN Provider Directory included in your enrollment package. Females should also select an OB/GYN physician.
2. Subject to applicable Nevada law, as a policyholder of an Individual Health Benefit Plan underwritten by HPN/SHL, you have the right to elect optional coverage for the treatment of Autism Spectrum Disorders (“ASD”) for each one of your eligible dependent child(ren). To be eligible, a dependent child must be under the age of 18 or, if enrolled in high school, under the age of 22. Upon receipt of this offer, you must elect to accept or decline the optional Individual ASD Rider for each eligible dependent child who you intend to enroll under your Individual Health Benefit Plan. Additional information regarding enrollment and cost of coverage is available upon request.

Effective Date:

The Effective Date must be after the signature date, but not greater than forty-five (45) days from the signature date on this Individual New Applicant Enrollment Form. Applicant is required to notify HPN/SHL’s Underwriting Department, in writing, of any changes in any Applicant’s medical condition, between the date the Applicant signs this form and the date benefit coverage becomes effective. If coverage is rescinded, the Member/Insured is prohibited from obtaining Individual health care coverage from HPN/SHL.

The requested Effective Date is subject to change based on the date the application is actually finalized and approved for issue by HPN/SHL’s Underwriting Department. If your Individual New Applicant Enrollment is approved for issue, your Effective Date will be communicated to you by HPN/SHL’s Underwriting department via a confirmation of coverage letter. Once the Individual New Applicant Enrollment Form is approved and the policy issued, HPN/SHL can not change the established effective date. Note: If you are adding an Eligible Family Member, outside of a Qualifying Event, the Effective Date will always be the first (1st) day of the calendar month following the month when the Individual Application Form is received and approved by HPN/SHL.

Effective Date Guidelines:

The requested Effective Date is either the 1st or the 15th of the month.

- 1st of the month – if the underwriting process is finalized by the 20th day of the requested month, your Effective Date will be the 1st day of that month. If the underwriting process is finalized after the 20th day of the requested month, the Effective Date will be the 1st day of the following month.
- 15th of the month – if the underwriting process is finalized by the 5th day of the following month, your Effective Date will be the 15th day of the requested month. If the underwriting process is finalized after the 5th day of the following month, the Effective Date will be the 15th day of that month.

INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

Section 4. Initial One Time Payment Only – Optional Credit Card Premium Payment

You may choose to make your initial premium payment by check, money order or credit card. Credit card payment is available for your first premium payment **only**. All subsequent payments will be made through monthly bills or by Electronic Fund Transfer (EFT). If choosing to pay by credit card, you must complete **all** of the following information:

Credit Card # _____ VISA Master Card AMEX
 Exp Date: (mm/yyyy) _____ Amount To Charge Upon Underwriting Approval \$ _____

I authorize HPN/SHL to bill my VISA, MasterCard or AMEX account for the payment amount shown above at the time my application is approved. I understand that 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.

Name (as it appears on the credit card)	Cardholder Signature:	Date
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Section 5. Electronic Funds Transfer (EFT) THIS OPTION IS ONLY AVAILABLE AFTER FIRST MONTH OF COVERAGE.

The monthly premium will be automatically withdrawn from the bank account listed on the application on the 10th day (or next business day if a weekend or holiday) of the month for which the premium is due.

Applicant/Policyholder Name:		Name of Bank Account holder(s): <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Name	Bank Routing/Transit Number	Bank Account Number:

As a convenience to me (us), I (we) authorize HPN/SHL to initiate debit entries to the account as per the pre-arranged payment authorization agreement at the bank or credit union (institution) listed above **equal to the monthly billed premium and/or any past due premiums** for this Individual Plan from HPN/SHL.

This authorization is to remain in full force and effect until HPN/SHL and the financial institution have received written notification from me (or either of us) of its termination in such a manner as to afford HPN/SHL and the financial institution a reasonable opportunity to act on it. I (or either of us) have the right to stop payment of the electronic debit entry by notification to HPN/SHL prior to charging the account.

After the account has been debited, I (we) have the right to have the amount of an erroneous debit refunded, provided I (we) send written notice of the error to HPN/SHL within fifteen (15) days of the issuance of the account statement or forty-five (45) days after posting, whichever occurs first. Should this right be exercised, I (we) will also notify HPN/SHL prior to such action to make arrangements for continuation or termination of coverage.

Instructions:

1. Please provide a **pre-printed voided check** from the account listed above in which premiums are to be withdrawn in order to facilitate the set-up of the electronic agreement via the Automated Clearing House (ACH).
2. After the application has been successfully processed by HPN/SHL, a confirmation letter will be sent to you indicating the date of the withdrawal as well as information about the due dates should you need to make a change.
3. In the event your monthly premiums increase, (at renewal or due to a change in age bracket), the increased premium rate will be deducted from your account.

X _____ X _____
 Signature of depositor(s) as appears on bank records Date

INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

Section 6. Medical Questionnaire Part I: This section must be completed for new Applicants and when adding an Eligible Family Member.

NOTE: A family applying together does not guarantee that all family members will be accepted for coverage. If only a portion of your family is accepted, you will be contacted by HPN/SHL for further instructions regarding your application for coverage.

Relationship to Applicant	Last Name	First Name MI	Sex	Birth date MM/DD/YY	Height	Weight
1. Applicant			<input type="checkbox"/> M <input type="checkbox"/> F		___feet ___inches	___lbs
Current Physician's name, address, phone and fax: _____						
2. Spouse/ DP			<input type="checkbox"/> M <input type="checkbox"/> F		___feet ___inches	___lbs
Current Physician's name, address, phone and fax: _____						
3. Child			<input type="checkbox"/> M <input type="checkbox"/> F		___feet ___inches	___lbs
Current Physician's name, address, phone and fax: _____						
4. Child			<input type="checkbox"/> M <input type="checkbox"/> F		___feet ___inches	___lbs
Current Physician's name, address, phone and fax: _____						
5. Child			<input type="checkbox"/> M <input type="checkbox"/> F		___feet ___inches	___lbs
Current Physician's name, address, phone and fax: _____						
6. Child			<input type="checkbox"/> M <input type="checkbox"/> F		___feet ___inches	___lbs
Current Physician's name, address, phone and fax: _____						
7. Child			<input type="checkbox"/> M <input type="checkbox"/> F		___feet ___inches	___lbs
Current Physician's name, address, phone and fax: _____						

Section 6. Medical Questionnaire Part II: Include information for you and all Eligible Family Members you wish to cover. Please complete the following questions and provide additional information in the Medical Details section under Question 27 when a "Yes" response has been selected.

<p>1. Within the past twelve (12) months has any individual applying for coverage had any other medical coverage?</p> <ul style="list-style-type: none"> ▪ If yes, name of Member/Insured _____ ▪ Prior medical carrier _____ <input type="checkbox"/> Group Policy <input type="checkbox"/> Individual Policy ▪ Effective date ___/___/___ Termination Date ___/___/___ Reason for termination _____ ▪ If this application is accepted, do you agree to discontinue your current coverage? 	<input type="checkbox"/> Yes <input type="checkbox"/> No
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INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

2. Is any individual applying for coverage currently pregnant, expecting a child with anyone, an expectant or surrogate parent or in the process of adopting a child? Please note: Coverage under HPN/SHL’s Individual Plans cannot be issued if you, your spouse/DP, or any female Eligible Family Member (including a dependent child), is now pregnant, unless the pregnant individual is considered HIPAA eligible as explained on page 9 of this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any individual applying for coverage smoked cigarettes or used tobacco in any form (smokeless tobacco, pipe, cigar, snuff or chewing tobacco) within the past twelve (12) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past five (5) years, has any individual applying for coverage used an illegal drug, had a diagnosis or treatment for alcohol or drug dependency, problem or abuse, or any alcohol or drug related moving violation, arrest or driver’s license suspension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past five (5) years, has any individual applying for coverage been a user of alcoholic beverages* in excess of two (2) drinks per day (14 drinks per week)? *(One drink equals 12 oz. of beer, 4 oz. of wine or 2 oz. of liquor)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past two (2) years, has any individual applying for coverage received a citation or conviction for driving under the influence (DUI) or any drug substance two or more times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any individual applying for coverage ever had cosmetic surgery, reconstruction, breast implantation or breast reduction? If yes, date of procedure ____/____/____ If breast implantation, saline or silicone _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 6. Medical Questionnaire Part III: HEALTH HISTORY - If nothing in a category applies, please select the “None” box. All questions must be answered.

IMPORTANT! Please provide details for all checked items, including “Other” in Medical Details under Question 27.

Has any person listed on this application within the past five (5) years ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions, diseases or disorders?

8. Heart or Circulatory System <input type="checkbox"/> Aneurysm, embolism, deep vein thrombosis (DVT), blood clot or stroke <input type="checkbox"/> Bypass surgery, angioplasty/stents, shunts or pacemaker <input type="checkbox"/> Palpitations, irregular heartbeat, heart murmur or mitral valve prolapse <input type="checkbox"/> Myocardial infarction (MI), chest, pain or angina <input type="checkbox"/> High or low blood pressure <input type="checkbox"/> Atrial or ventricular septal defect <input type="checkbox"/> Other	<input type="checkbox"/> None
9. Brain and Nervous System <input type="checkbox"/> Head injury or concussion <input type="checkbox"/> Seizures, epilepsy or fainting <input type="checkbox"/> Headaches, migraines or chronic headaches <input type="checkbox"/> Alzheimer’s, dementia, Parkinson’s disease, paralysis, or transient ischemic attack (TIA) <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Other	<input type="checkbox"/> None
10. Digestive System <input type="checkbox"/> Gastroesophageal reflux (GERD, acid reflux), ulcer or hiatal hernia <input type="checkbox"/> Disorder of the gallbladder, pancreas, stomach, intestine or colon <input type="checkbox"/> Acute or chronic liver inflammation, cirrhosis or fatty liver <input type="checkbox"/> Rectal bleeding, hemorrhoids, diverticulitis, diverticulosis or pancreatitis <input type="checkbox"/> Surgical treatment for obesity, gastric bypass or banding <input type="checkbox"/> Colitis, regional ileitis, irritable bowel syndrome (IBS) or Crohn’s disease <input type="checkbox"/> Liver disease, hepatitis A, B, C, D or E <input type="checkbox"/> Other	<input type="checkbox"/> None
11. Lungs/Respiratory System <input type="checkbox"/> Asthma, allergies, bronchitis or sinusitis <input type="checkbox"/> Sleep apnea/ breathing difficulties while sleeping <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD), emphysema or cystic fibrosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other	<input type="checkbox"/> None
12. Blood, Gland, Endocrine, Adrenal or Metabolic System <input type="checkbox"/> Adrenal, thyroid, pituitary, breast or other gland disorder <input type="checkbox"/> Diabetes (type I insulin dependent) or type II (non-insulin dependent) <input type="checkbox"/> Immune system disorder (other than AIDS) <input type="checkbox"/> Raynaud’s disease, phenomenon or syndrome <input type="checkbox"/> Acquired Immunodeficiency (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) <input type="checkbox"/> Anemia or hemophilia <input type="checkbox"/> Systemic lupus or scleroderma <input type="checkbox"/> Other	<input type="checkbox"/> None

INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

<p>13. Bone, Joint, Disc, Skeletal and Muscular System</p> <p><input type="checkbox"/> Rheumatoid arthritis, osteoarthritis, fibromyalgia or other arthritis <input type="checkbox"/> Chiropractic treatments</p> <p><input type="checkbox"/> Disorder of back, hip, shoulder, neck, spine or other joint <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Osteopenia, osteoporosis, fracture, dislocation or internal knee derangement</p> <p><input type="checkbox"/> Amputation, prosthetic limbs or devices or internal fixtures (screws, plates, pins)</p> <p><input type="checkbox"/> Connective tissue disorder or systemic lupus</p> <p><input type="checkbox"/> Rotator cuff syndrome, bursitis, tendonitis, gout, TMJ (Temporomandibular Joint Syndrome) or carpal tunnel syndrome</p>	<p><input type="checkbox"/> None</p>
<p>14. Kidney or Urinary System</p> <p><input type="checkbox"/> Kidney infection (pyelonephritis) or disorder <input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Albuminuria, bladder or urinary tract infection, urinary incontinence or disorder</p>	<p><input type="checkbox"/> None</p>
<p>15. Nervous, Mental, Emotional or Behavioral Disorders</p> <p><input type="checkbox"/> Anxiety, minor depression, adjustment disorder or panic disorder <input type="checkbox"/> Attention deficit disorder (ADD)</p> <p><input type="checkbox"/> Major depression, bipolar depression (manic depression) or schizophrenia <input type="checkbox"/> Current or prior counseling</p> <p><input type="checkbox"/> Phobias, obsessive compulsive disorder or post traumatic stress syndrome <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> None</p>
<p>16. Female Reproductive System</p> <p><input type="checkbox"/> Vaginal, cervical, ovarian or uterine disorder <input type="checkbox"/> Menstrual or menopausal disorder</p> <p><input type="checkbox"/> Disorder of the breast, abnormal pap smear or abnormal mammogram <input type="checkbox"/> Infertility or complications of pregnancy</p> <p><input type="checkbox"/> Abnormal uterine bleeding, endometriosis, uterine fibroids or uterine prolapse <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> None</p>
<p>17. Male Reproductive System</p> <p><input type="checkbox"/> Prostate disorder, elevated PSA or prostatitis <input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> Erectile dysfunction, impotence, penile or testicular disorder <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> None</p>
<p>18. Cancer, Cyst, Polyp, Lump or Tumor</p> <p><input type="checkbox"/> Cancer, location and type (benign or malignant)_____</p> <p> </p> <p><input type="checkbox"/> Melanoma, cyst, polyp, lump, tumor or growth of any kind, location and type (benign or malignant)_____</p>	<p><input type="checkbox"/> None</p>
<p>19. Congenital Abnormalities, Birth Defects or Development Disorders</p> <p><input type="checkbox"/> Autism <input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Cleft lip, nose or palate <input type="checkbox"/> Down syndrome</p> <p><input type="checkbox"/> Mental retardation <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> None</p>
<p>20. Eye, Ears, Nose or Throat Disorders</p> <p><input type="checkbox"/> Disease(s) of tonsils or adenoids <input type="checkbox"/> Ear or sinus infection</p> <p><input type="checkbox"/> Deviated nasal septum or nasal polyps <input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Cataract, glaucoma or retina detachment <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> None</p>
<p>21. Sexually Transmitted Diseases (STD)</p> <p><input type="checkbox"/> Gonorrhea or syphilis <input type="checkbox"/> Genital herpes or genital warts</p> <p><input type="checkbox"/> Human papilloma virus (HPV) <input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Other</p>	<p><input type="checkbox"/> None</p>
<p>22. Skin Disorders</p> <p><input type="checkbox"/> Fungus infections, impetigo or dermatitis <input type="checkbox"/> Actinic keratosis (AK)</p> <p><input type="checkbox"/> Skin cancer (basal or squamous) <input type="checkbox"/> Eczema or psoriasis</p> <p><input type="checkbox"/> Skin cancer (melanoma) <input type="checkbox"/> Acne or rosacea</p> <p><input type="checkbox"/> Other</p>	<p><input type="checkbox"/> None</p>
<p>23. In the past five (5) years has any individual applying for coverage contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any health care professional?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

Section 7. Verification Telephone Call

I (We) understand that HPN/SHL may acknowledge my (our) application for healthcare coverage with a verification telephone call. It is my (our) understanding that this verification call is a routine process for those applying for coverage with HPN/SHL and that this telephone call will be recorded. I (We) also understand that, should a verification call be made, my (our) application will not be given further consideration if verification is not completed. I/my spouse/DP may be contacted at the following number(s), between **8:00 a.m. – 4:30 p.m.:**

Applicant

Spouse/DP (if applying for coverage)

Preferred language (if other than English)_____

Preferred language (if other than English)_____

Telephone Number: ()_____

Telephone Number: ()_____

Time: _____ a.m./p.m. Work () Home () Other ()

Time: _____ a.m./p.m. Work () Home () Other ()

Alternate Telephone Number()_____

Alternate Telephone Number()_____

Time:_____ a.m./p.m. Work () Home () Other ()

Time:_____ a.m./p.m. Work () Home () Other ()

Section 8: Authorization to Release Medical Records

I (We) authorize any hospital, clinic, institution, physician, or other health care provider to disclose the entire medical record of any Applicant listed herein to HPN/SHL. This information may be used/disclosed only for the purpose(s) of Medical Underwriting/Risk Assessment. This authorization shall remain in effect for a period of thirty (30) months from the date this application is signed below. My authority to authorize the disclosure of Applicants other than myself is based upon my ability to act as personal representative for the purposes of securing health coverage for the named individuals.

Important to note: It is your responsibility to obtain and submit a copy of requested medical records for the past five (5) years, if applicable. Also, HPN/SHL is not responsible for any payment related to the release of requested medical records. Charges incurred will be the sole responsibility of the applicant(s),

The information you authorize to be disclosed may be re-disclosed by HPN/SHL and the information may no longer be protected under the Federal Privacy Rule. You have the right to revoke any written authorization, except to the extent that we have taken action in reliance on the authorization, by writing to us at Health Plan of Nevada, Inc. or Sierra Health and Life Insurance Company, Inc. Attn. Medical Underwriting Dept., P. O. Box 14930, Las Vegas, NV 89114-4930.

This authorization is voluntary and you may refuse to sign this authorization. However, your failure to complete this portion of your application may either result in a higher premium rate or prevent us from offering health insurance to you.

Applicant/Court Appointed Legal Guardian's Signature: _____

Date of Birth (MM/DD/YYYY) _____ Date of Signature _____

Spouse/DP's Signature _____

Date of Birth (MM/DD/YYYY) _____ Date of Signature _____

Eligible Family Member's Signature (18 yrs and over) _____

Date of Birth (MM/DD/YYYY) _____ Date of Signature _____

Eligible Family Member's Signature (18 yrs and over) _____

Date of Birth (MM/DD/YYYY) _____ Date of Signature _____

Applicant is acting as the personal representative for all dependents listed herein.

INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

Section 9. Acknowledgements and Application Completion SIGNATURE REQUIRED - By signing this document:

1. I (We) hereby apply to HPN/SHL for coverage now being offered to my Eligible Family Member(s) and me, if any, as shown on page 1. I (We) understand that this application is subject to acceptance by HPN/SHL and that if an Agreement is issued, services will be available subject to the terms, exclusions, limitations and benefits described in the HPN/SHL Agreement of Coverage (AOC) and the applicable Attachment A Benefit Schedule.
2. I (We) understand that I am (we are) entitled to a copy of this form. Notification of acceptance or rejection of my (our) application will be sent to me (us) by HPN/SHL. When the application is accepted, the Effective Date will be indicated.
3. I (We) understand if other healthcare coverage is obtained and not terminated, then HPN/SHL shall have the right to terminate coverage.
4. I (We) understand that once the Individual New Applicant Enrollment Form is approved and the policy issued, HPN/SHL cannot change the established Effective Date.
5. I (We) understand if this application is declined I (we) will receive a full refund of the premium paid; or, if I (we) are not satisfied for any reason or if the premium rates are not acceptable, within ten (10) days of receiving the AOC, I (we) may return the AOC materials and request a full refund of the premium paid, less any claims paid, if applicable.
6. I (We) understand that this form may become a part of my medical records.
7. I (We) understand that there may be Preexisting Condition Limitations and Waiting Periods for certain conditions, except for a guaranteed issue policy under HIPAA. I (We) understand that my (our) coverage and the coverage of my (our) Eligible Family Members may be subject to those exclusions and Waiting Periods.
8. I (We) understand that if I (we) perform an act or practice that constitutes fraud or, if I (we) make any intentional misrepresentation of material fact, HPN/SHL 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.
9. I (We) understand HPN/SHL has the right to increase premiums for this Agreement after providing sixty (60) days prior notice to the Applicant. Any such increase will apply to all Applicants in the same class. In addition, an increase will be applied if an Applicant has a birthday that results in an age reclassification on the rate charts. Applications are subject to medical underwriting which may result in an increase in premium or rejection of application unless the Applicant qualifies for a State mandated Standard or Basic HIPAA plan according to Nevada state law.
10. If applying for HIPAA Standard or Basic coverage, please attach proof that Applicant meets the following HIPAA eligibility requirements:
 - My HIPAA qualifying event occurred no more than sixty-three (63) days prior to the date of this Application;
 - I have a minimum aggregate period of eighteen (18) months of Creditable Coverage as of the date of this Application;
 - My most recent healthcare coverage was under a Group Plan which was not terminated due to fraud or non-payment of premium;
 - I have exhausted COBRA or similar continuation of coverage, if applicable;
 - I am not covered by other healthcare coverage including, but not limited to, Medicare or Medicaid; or
 - My most recent prior creditable coverage was under a Basic or Standard Health Benefit Plan and was not renewed by a carrier who discontinued offering and renewing individual health benefit plans.
11. I (We) understand if I am (we are) requesting a change to an HPN/SHL Plan option with a higher level of benefits, I (we) must complete the entire HPN/SHL Individual New Applicant Enrollment Form.
12. I (We) understand that the payment submitted with this Application will be processed at the time of approval.

I (We) represent that all statements and answers in this application including the reverse side and attachments, are true and complete to the best of my (our) knowledge. I (We) agree that this shall be the basis of my (our) acceptance of membership. I (We) understand when information provided to HPN/SHL in this Individual New Applicant Enrollment Form is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage, HPN/SHL shall have the right to retroactively increase 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 HPN/SHL within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to date.

It is important that you carefully read and fully understand the following: All Applicants age 18 and over must personally read, agree to, and sign as indicated. I (We) understand and accept this Application.

Applicant/Court Appointed Legal Guardian's Signature: _____ **Date** _____

Spouse/DP's Signature: _____ **Date** _____

Eligible Family Member's Signature (18 yrs and over): _____ **Date** _____

Eligible Family Member's Signature (18 yrs and over): _____ **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.