HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

# 2021 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 (11/01/20 – 1/15/21)

☐ Qualifying Life Event Type of Event: Date of Event ____/____/____

☐ Birth or Adoption ☐ Marriage / Divorce ☐ Permanent Move

☐ Loss of Coverage ☐ Other_____

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

***Select medical plan by checking the box***

| MyHPN Solutions HMO Plans (Clark/Nye/Washoe County residents only) | | MySHL Solutions EPO & HSA Plans (Clark County residents only) | | |
|---|---|---|---|---|
| Bronze HMO* ☐ ☐ ☐ 10 13 14 | Silver HMO* ☐ ☐ ☐ 1.1 3.1 4 | Bronze EPO* ☐ ☐ ☐ 9 10 11 | Silver EPO* ☐ ☐ ☐ ☐ ☐ ☐ 1 2 6 7 8 9 | |
| Gold HMO* ☐ 7 | | Gold EPO* ☐ 7 | Bronze HSA EPO* ☐ 3.1 | Catastrophic EPO* ☐ 1 |

**Optional products** (additional premium applies)

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

## STEP 02 Applicant information (please write clearly)

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

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

| First name | Last 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_____ Phone _____

Agency name_____ Agent name_____

Sales Rep_____ Effective Date_____

***You can also enroll in a health insurance plan for you and your family through the Silver State Health Insurance Exchange (Nevada's state-based health insurance exchange). The Silver State Health Insurance Exchange allows you to get quotes from different insurance companies that are available on the Exchange. You can compare different plans, get quotes and find out if you qualify for financial assistance. The Silver State Health Insurance Exchange is the only way to receive financial assistance for your health insurance. You can enroll online by visiting www.nevadahealthlink.com or by calling 1-800-547-2927**, TTY **711.**

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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 Dependents**

| Member information | | | | HPN Options Only | |
|---|---|---|---|---|---|
| | First name / Last name / MI | | Date of birth / / | Primary Care Provider (PCP)[2] or Pediatrician | OB/GYN (for females, age 15+) |
| **Applicant** | Social security # (age 5+) - - | Valid Nevada ID # (age 19+) Required | Gender ☐ Male ☐ Female | | |
| | Medicare A/B eligible ☐ Y ☐ N | Tobacco use[1] ☐ Y ☐ N | | | |
| | First name / Last name / MI | | Date of birth / / | Primary Care Provider (PCP)[2] or Pediatrician | OB/GYN (for females, age 15+) |
| **Spouse/D.Partner** | Social security # (age 5+) - - | Valid Nevada ID # (age 19+) Required | Gender ☐ Male ☐ Female | | |
| | Medicare A/B eligible ☐ Y ☐ N | Tobacco use[1] ☐ Y ☐ N | | | |
| | First name / Last name / MI | | Date of birth / / | Primary Care Provider (PCP)[2] or Pediatrician | OB/GYN (for females, age 15+) |
| **Child 1** | Social security # (age 5+) - - | Valid Nevada ID # (age 19+) Required | Gender ☐ Male ☐ Female | | |
| | Medicare A/B eligible ☐ Y ☐ N | Tobacco use[1] ☐ Y ☐ N | | | |
| | First name / Last name / MI | | Date of birth / / | Primary Care Provider (PCP)[2] or Pediatrician | OB/GYN (for females, age 15+) |
| **Child 2** | Social security # (age 5+) - - | Valid Nevada ID # (age 19+) Required | Gender ☐ Male ☐ Female | | |
| | Medicare A/B eligible ☐ Y ☐ N | Tobacco use[1] ☐ Y ☐ N | | | |
| | First name / Last name / MI | | Date of birth / / | Primary Care Provider (PCP)[2] or Pediatrician | OB/GYN (for females, age 15+) |
| **Child 3** | Social security # (age 5+) - - | Valid Nevada ID # (age 19+) Required | Gender ☐ Male ☐ Female | | |
| | Medicare A/B eligible ☐ Y ☐ N | Tobacco use[1] ☐ Y ☐ N | | | |
| | First name / Last name / MI | | Date of birth / / | Primary Care Provider (PCP)[2] or Pediatrician | OB/GYN (for females, age 15+) |
| **Child 4** | Social security # (age 5+) - - | Valid Nevada ID # (age 19+) Required | Gender ☐ Male ☐ Female | | |
| | Medicare A/B eligible ☐ Y ☐ N | Tobacco use[1] ☐ Y ☐ N | | | |
| | First name / Last name / MI | | Date of birth / / | Primary Care Provider (PCP)[2] or Pediatrician | OB/GYN (for females, age 15+) |
| **Child 5** | Social security # (age 5+) - - | Valid Nevada ID # (age 19+) Required | Gender ☐ Male ☐ Female | | |
| | 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 Provider (PCP) or Pediatrician from the Health Plan of Nevada provider directory available at HealthPlanofNevada.com. Females should also select an OB/GYN physician.

## STEP 04 Acknowledgements and application completion - SIGNATURE REQUIRED

By signing this document:

- 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 if 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.
- **Applicant attests they are not eligible and/or enrolled in Medicare Part A and/or Part B at the time of this application.**
- Applicant understands they are entitled to a copy of this form.
- 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.
- 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.

**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_____

**WARNING:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes 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 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.**

**Set your delivery preferences. Opt-in to receive information electronically, request paper documents or update your information. Visit HealthPlanofNevada.com or SierraHealthandLife.com and sign in. First-time users will need to create an account using their member ID.**

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.**

**AUTHORIZED REPRESENTATIVE.** If an Authorized Representative is completing 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 APPOINTED LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ON BEHALF OF APPLICANT:**

Signature_____ Date_____

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FOR OFFICE USE ONLY:

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**Premium payment options** **PLEASE PRINT CLEARLY**

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.

| Applicant/Member<br>First name | Last name | MI |
|---|---|---|
| Applicant/Member email address | Phone<br>– – | |

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: _____

The following are the only acceptable third parties who may pay HPN/SHL premiums on the Member/Insured's behalf:

- Ryan White HIV/AIDS program under the Title XXVI of the Public Health Service Act;
- Indian tribes, tribal organizations, or urban Indian organizations;
- Employer;
- State and Federal government programs; or
- Family members.

If payment from the Member/Insured is received and premium is determined to be from a non-acceptable third party, the Member/Insured will be informed that the payment will be returned and that the premium payment remains due by an acceptable party. If the premium payment is not received from an acceptable party within the premium grace period the policy will be terminated for nonpayment of premium.

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<br>Checking Savings |
|---|---|
| Routing # | Bank account # |

Amount to charge upon application submission $_____

Select day of month for recurring payments _____
*(Date will be the 10th day of the month if no date is entered)*

☐ ***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 for the payment amount shown above at the time my Application is submitted. I also 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.

☐ ***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.**

☐ ***Recurring Monthly Payments*** I authorize Health Plan of Nevada/Sierra Health and Life to charge my credit/debit card OR debit my bank account 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 date specified above (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_____