HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

FOR SALES USE ONLY:
SIEBEL POLICY _____
EFFECTIVE DATE _____
INDIVIDUAL REP _____

2021 Individual Change Form

Section 1: All information must be completed by subscriber

First Name	Last Name	M.I.

Member ID	DOB	SSN	Requested Effective Date

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

- ☐ Personal Information (Section 2)
- ☐ Change Coverage (Section 3)
- ☐ Ancillary Coverage (Section 4)
- ☐ Dependents (circle one): Add - Remove (Section 5)
- ☐ Termination (Section 6)
- ☐ Other (Explanation): _____

_____

Set your delivery preferences (choose one). 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 be directed to create an account using their member ID.

☐ **(Initial).** I am electing to receive all future notices and/or documents from Health Plan of Nevada/Sierra Health and Life in electronic format.

☐ **(Initial).** I am declining to receive all future notices and/or documents from Health Plan of Nevada/Sierra Health and Life in electronic format.

Section 2: Personal Information

New Name (please attach legal documentation, i.e., Marriage License, Driver's License)

Current Name:	Name Change:

New Address/Phone/Email

Street:	Apt #:	Phone:
City:	State:	ZIP:
Email Address:	Social Security #:	Valid Nevada Driver's License / ID Number:

Section 3: To Change Coverage ☐ Open Enrollment (11/1/20 to 1/15/21 only) ☐ First of month following 90 day wait

Health Plan of Nevada: MyHPN Solutions HMO		Sierra Health and Life: MySHL Solutions EPO	
Bronze HMO	☐ 10 ☐ 13 ☐ 14	Bronze EPO	☐ 9 ☐ 10 ☐ 11
Silver HMO	☐ 1.1 ☐ 3.1 ☐ 4	Silver EPO	☐ 1 ☐ 2 ☐ 6 ☐ 7 ☐ 8 ☐ 9
		Gold EPO	☐ 7
Gold HMO	☐ 7	Bronze HSA EPO	☐ 3.1
		Catastrophic EPO	☐ 1

Section 4: Ancillary Coverage[2]

Type of change (check the boxes that apply)

Dental:

- ☐ Add PPO Adult Dental (ages 19+)
- ☐ Add DHMO Dental (all covered 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 ☐ **Removal** of dependents

	Last Name	First Name	MI	DOB	Gender M	Gender F	SSN (age 5+)	Valid NV DL/ID # (age 19+)	Tobacco use[1] Y/N
Spouse									
Child									
Child									
Child									

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

☐ Newborn date _____ ☐ Adoption date _____ ☐ Other_____

☐ Marriage date _____ ☐ Loss of coverage _____

Section 6: 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 7: Signature (required)

NOTE: HPN/SHL reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber thirty (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 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 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] Within the past six months has used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)

[2] 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 as follows: If requested between the first and the 15th of the month, the change will be effective on the first of the following month. If requested between the 16th and last day of the month, the change will be effective on the first of the subsequent month.