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.®

It's easy to enroll with Health Plan of Nevada or Sierra Health and Life

Enrollment Packet

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

INDIVIDUAL APPLICANT ENROLLMENT FORM – NEVADA RESIDENTS ONLY

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)
- ☐ Option 1*
- ☐ Option 2
- ☐ Option 3* (POS)
- ☐ Option 4
- ☐ Optional HMO Dental
- ☐ Optional Autism Rider

*12-month Maternity Waiting Period applies

SHL PPO Distinct Advantage
(No Maternity Coverage)
- ☐ Plan 1 – 1000
- ☐ Plan 2 – 1500
- ☐ Plan 3 – 2500
- ☐ Plan 4 – 5000
- ☐ Plan 5 – 7500
- ☐ Plan 6 – 10000
- ☐ Optional Autism Rider

SHL HSA Sierra Simplicity
(No Maternity Coverage)
- ☐ Plan A – 1500
- ☐ Plan B – 2500
- ☐ Plan C – 2500
- ☐ Plan D – 5000
- ☐ Optional Autism Rider

HIPAA Guarantee Issue[1]
(Basic = No Maternity Coverage)
- ☐ PPO Standard HIPAA
- ☐ Optional Standard Autism Rider
- ☐ PPO Basic HIPAA
- ☐ HMO Standard HIPAA
- ☐ Optional Standard Autism Rider
- ☐ HMO Basic HIPAA
- ☐ Optional HMO Dental

[1]See 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: _____

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			☐ M ☐ F			
2.	Spouse/DP			☐ M ☐ F			
3.	Child			☐ M ☐ F			☐ Accept ☐ Decline
4.	Child			☐ M ☐ F			☐ Accept ☐ Decline
5.	Child			☐ M ☐ F			☐ Accept ☐ Decline
6.	Child			☐ M ☐ F			☐ Accept ☐ Decline
7.	Child			☐ M ☐ F			☐ Accept ☐ 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.

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

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): ☐Checking ☐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**

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		☐ M ☐ F		____feet ____inches	____lbs
Current Physician's name, address, phone and fax: _____					
2. Spouse/ DP		☐ M ☐ F		____feet ____inches	____lbs
Current Physician's name, address, phone and fax: _____					
3. Child		☐ M ☐ F		____feet ____inches	____lbs
Current Physician's name, address, phone and fax: _____					
4. Child		☐ M ☐ F		____feet ____inches	____lbs
Current Physician's name, address, phone and fax: _____					
5. Child		☐ M ☐ F		____feet ____inches	____lbs
Current Physician's name, address, phone and fax: _____					
6. Child		☐ M ☐ F		____feet ____inches	____lbs
Current Physician's name, address, phone and fax: _____					
7. Child		☐ M ☐ 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.

1. Within the past twelve (12) months has any individual applying for coverage had any other medical coverage?	☐ Yes ☐ No
▪ If yes, name of Member/Insured_____	
▪ Prior medical carrier_____ ☐ Group Policy ☐ Individual Policy	
▪ Effective date_____/_____/_____ Termination Date_____/_____/_____ Reason for termination_____	
▪ If this application is accepted, do you agree to discontinue your current coverage?	

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.	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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)	☐ Yes ☐ 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?	☐ Yes ☐ 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_____	☐ Yes ☐ 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** ☐ None

- ☐ Aneurysm, embolism, deep vein thrombosis (DVT), blood clot or stroke
- ☐ Bypass surgery, angioplasty/stents, shunts or pacemaker
- ☐ Palpitations, irregular heartbeat, heart murmur or mitral valve prolapse
- ☐ Myocardial infarction (MI), chest, pain or angina
- ☐ High or low blood pressure
- ☐ Atrial or ventricular septal defect
- ☐ Other

9. **Brain and Nervous System** ☐ None

- ☐ Head injury or concussion
- ☐ Seizures, epilepsy or fainting
- ☐ Headaches, migraines or chronic headaches
- ☐ Alzheimer's, dementia, Parkinson's disease, paralysis, or transient ischemic attack (TIA)
- ☐ Multiple sclerosis
- ☐ Other

10. **Digestive System** ☐ None

- ☐ Gastroesophageal reflux (GERD, acid reflux), ulcer or hiatal hernia
- ☐ Disorder of the gallbladder, pancreas, stomach, intestine or colon
- ☐ Acute or chronic liver inflammation, cirrhosis or fatty liver
- ☐ Rectal bleeding, hemorrhoids, diverticulitis, diverticulosis or pancreatitis
- ☐ Surgical treatment for obesity, gastric bypass or banding
- ☐ Colitis, regional ileitis, irritable bowel syndrome (IBS) or Crohn's disease
- ☐ Liver disease, hepatitis A, B, C, D or E
- ☐ Other

11. **Lungs/Respiratory System** ☐ None

- ☐ Asthma, allergies, bronchitis or sinusitis
- ☐ Sleep apnea/ breathing difficulties while sleeping
- ☐ Pulmonary embolism
- ☐ Shortness of breath
- ☐ Chronic obstructive pulmonary disease (COPD), emphysema or cystic fibrosis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Other

12. **Blood, Gland, Endocrine, Adrenal or Metabolic System** ☐ None

- ☐ Adrenal, thyroid, pituitary, breast or other gland disorder
- ☐ Diabetes (type I insulin dependent) or type II (non-insulin dependent)
- ☐ Immune system disorder (other than AIDS)
- ☐ Raynaud's disease, phenomenon or syndrome
- ☐ Acquired Immunodeficiency (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)
- ☐ Anemia or hemophilia
- ☐ Systemic lupus or scleroderma
- ☐ Other

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

24. Has any individual applying for coverage been scheduled for any follow-up visits, advised to undergo further testing or had surgery recommended?	☐ Yes ☐ No
25. Has any individual applying for coverage ever had an application or policy declined, rated or had coverage modified by any health or life insurer?	☐ Yes ☐ No
26. In the past five (5) years, has any individual applying for coverage had any signs, symptoms, diagnosis, been hospitalized, taken medication, had treatment for any other disease, disorder, injury or condition that is not listed on this application?	☐ Yes ☐ No

27. **MEDICAL DETAILS: Please refer to Question # 27. Medical Details:** If you selected "Yes" in Part II (Questions # 1 – 7) or Part III (Questions #23 - 26) or checked any box other than "None" in Part III (Questions #8 - 22) of the Health History, please provide question number and explain in FULL DETAIL below. Use additional sheet, if necessary.

Question Number	Family Member Name and Applicant Number	Symptom/ Condition/ Diagnosis	Date of Onset	Date Recovered or Date last treated	Medication and date last taken	Physician's Name, Phone, Fax & Address

28. **MEDICATIONS:** List all medications taken currently or within the past two (2) years by the Applicant or any family member listed on this application. Use additional sheet, if necessary.

List Corresponding Applicant Name and Number	Medication/ Dosage/ Frequency	Illness for which Medication was Prescribed	Date Medication Started	Date Medication Completed	Still on this Medication	Physician's Name, Phone, Fax & Address
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

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

Preferred language (if other than English)_____

Telephone Number: ( )_____

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

Alternate Telephone Number( )_____

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

Spouse/DP (if applying for coverage)

Preferred language (if other than English)_____

Telephone Number: ( )_____

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

Alternate Telephone Number( )_____

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/YYY) _____ Date of Signature_____

Spouse/DP's Signature_____

Date of Birth (MM/DD/YYY) _____ Date of Signature_____

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

Date of Birth (MM/DD/YYY) _____ Date of Signature_____

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

Date of Birth (MM/DD/YYY) _____ Date of Signature_____

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

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.