HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

UnitedHealthcare
A UnitedHealth Group Company

Enrollment Form

Instructions

Shaded areas at the top of the form are to be completed by your Employer prior to final submission and approval.

Section A: Employee Information

- Please complete information requested.

Section B: Eligible Family Member(s) Information

- List Eligible Family Member(s) who are enrolling. You may attach an additional sheet if necessary.
- If declining any medical coverage offered you, your spouse, or your Eligible Family Member(s), you **must** complete Section E Waiver of Coverage.

HPN Plans Only:

- Primary Care Physician (PCP) selection is not required for HPN Open Access or SHL Plans.
- Select a PCP from the HPN Provider Directory for you and each of your Eligible Family Member(s) by filling in the PCP name and corresponding Provider number. You may choose a different PCP for each member in your family.

Section C: Coverage Selection

- Please check all boxes that apply.
- Benefit plans offered are dependent upon your Employer's selection.
- Complete the Life Insurance Beneficiary's information requested if your Employer offers this benefit.

Section D: Other Medical Coverage Information

- Section D must be completed if applicable.
- You may attach an additional sheet if necessary.

Section E: Waiver of Coverage Section E **must** be completed and signed if you are declining any Employer offered coverage for you, your spouse, or your Eligible Family Member(s).

Section F: Signature

- Section F **must** be signed and dated by the Employee.
- Your signature indicates that you have read, understand and agree to the terms and conditions of coverage provided through your Employer. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

Terms and Conditions – Please read carefully before signing

I hereby apply for medical benefit coverage offered through my Employer and underwritten by Health Plan of Nevada ("HPN") or Sierra Health and Life (SHL), UnitedHealthcare Companies and ancillary products underwritten by HPN, SHL and/or UnitedHealthcare and its affiliates ("UHC and Affiliates") for my Eligible Family Member(s) and myself. I agree to and understand the following:

1. To be bound by the Group Enrollment Agreement ("Agreement") signed by my Employer and UHC and Affiliates.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. UHC and Affiliates or a designee may access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, billing, payment or healthcare operations of the Agreement or Plan.

HPN Medical Temporary Enrollment ID Card		SHL Medical Temporary Enrollment ID Card		Complete the attached temporary Enrollment ID Cards and keep until you receive your permanent ID Card. **HPN Member Services** (702) 242-7300 or 1-800-777-1840 **SHL Member Services** (702) 242-7700 or 1-800-888-2264
Name:		Name:		
Effective Date:		Effective Date:		
Employer Name:		Employer Name:		
Group Number:		Group Number:		
Coverage shall not begin until acceptance of your enrollment.		Coverage shall not begin until acceptance of your enrollment.		

4. Any incomplete or incorrect material omission or misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my and/or my Eligible Family Member(s) membership in a healthcare Plan with UHC and Affiliates
5. Coverage shall not begin until acceptance of this signed Enrollment Form and any applicable premiums have been received and accepted by UHC and Affiliates. Upon acceptance of this Enrollment Form and premium, UHC and Affiliates shall be bound by the terms of the Agreement or Plan, and any Amendments thereto.
6. If enrolling in an HMO or POS medical plan underwritten by HPN, my Eligible Family Member(s) and I must live or work in HPN's Service Area (except under certain circumstances specifically negotiated by Employer).

UnitedHealthcare and Affiliates

Medical Coverage provided by:

Health Plan of Nevada, a UnitedHealthcare Company
P.O. Box 15645
Las Vegas, NV 89114-5645
Member Services: (702) 242-7300 or 1-800-777-1840

Sierra Health and Life, a UnitedHealthcare Company
P.O. Box 15645
Las Vegas, NV 89114-5645
Member Services: (702) 242-7700 or 1-800-888-2264

Dental Coverage provided by:

Sierra Health and Life
Member Services: (702) 242-7700 or 1-800-888-2264

United Healthcare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115-0450
Contact Number: 1-877-816-3596

Life Insurance Coverage provided by:

Sierra Health and Life
Member Services: (702) 242-7700 or 1-800-888-2264

United Healthcare Insurance Company
Contact Number: 1-866-615-8727

Vision Coverage provided by:

Health Plan of Nevada
Member Services: (702) 242-7300 or 1-800-777-1840

Sierra Health and Life
Member Services: (702) 242-7700 or 1-800-888-2264

United Healthcare Insurance Company
Contact Number: 1-800-638-3120

Employee: To receive your **ID** card, please CLEARLY complete all non-shaded areas and sign Section F.	Employer Verification Signature and Date:	
Shaded Areas at Top of This Form To Be Completed by Employer	Group/Subgroup Number:	
Date of Hire[1] (mm/dd/yy):	Group Name:	
	Requested Effective Date or Date of Change:	

Position/Title: _____ Hours Worked per Week: _____ Dept. Code: _____ Class Code: _____ Annual Salary(for Life Ins.): $_____ Employee # (if applicable): _____	Reason for Application □ New Hire □ Rehire □ New Group Plan □ Open Enrollment □ Status Change _____ □ Change Name/Address □ Dependent Add □ Other _____ □ Special Enroll Event[2] Date_____ Termination □ Voluntary □ Involuntary	Employee Type (check all that apply) □ Active □ Hourly □ Salary □ Union □ Non-Union □ Retired □ Other_____ □ COBRA or State Continuation Start Date ____/____/____ End date ____/____/____

A. Employee Information

Last Name	First Name	MI	Social Security Number		Home Phone Cell Phone
Address	Apt # / City		State	Zip Code	Email Address
Date of Birth (mm/dd/yy)	Sex □ M □ F	Date of Hire[1] (mm/dd/yy)	HPN Primary Care Provider Code[3]		HPN OB/GYN Provider Code[3]
Marital Status: □ Single □ Married □ Divorced □ Widowed			Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)? □ Yes □ No		
Do you receive a paycheck? □ Yes □ No If Yes, how often?					

B. Eligible Family Member(s) Information[4] (Complete only if Dependent coverage is desired. Attach additional sheet, if necessary).

Relationship (if relationship is different than the options listed, please write the relationship)				Sex	HPN Primary Care Provider Code[3]	HPN OB/GYN Provider Code[3]	Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)?
Spouse	Last Name / Social Security #	First Name / Birthdate	MI	☐ M ☐ F			□ Yes □ No
Child	Last Name / Social Security #	First Name / Birthdate	MI	☐ M ☐ F			□ Yes □ No
Child	Last Name / Social Security #	First Name / Birthdate	MI	☐ M ☐ F			□ Yes □ No
Child	Last Name / Social Security #	Last Name / Birthdate	MI	☐ M ☐ F			□ Yes □ No

C. Coverage Selection (Please check all that apply. Benefit offerings are dependent upon employer selection.)

	HPN HMO Medical	HPN POS Medical	SHL Medical	Dental	Vision	Basic Employee Life & AD&D				Basic Dep Life	
Check box(es):	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Life	□ Yes □ No	AD&D	□ Yes □ No		□ Yes □ No
Plan Name:											

Life Insurance Beneficiary's Full Name and Address	Relationship to the Employee

*[1] If the employee is reclassified to full-time status, please provide the date of full-time employment. [2] Legal documentation must be attached. [3] Refer to the HPN Primary Care Provider (PCP) Directory. Enter the number found next to the Provider you choose as a PCP. PCP Selection: HPN HMO & POS Plans = required; HPN Open Access Plans = **not** required, but recommended; SHL Plans = **not** required. Females may choose one medical care PCP and one OB/GYN. [4] If declining any medical coverage offered you or your Eligible Family Members, you must complete Section E Waiver of Coverage.*

Employee Name: ______________________________________ SSN: ________________________

Relationship				Sex	HPN (only) Primary Care Provider Code	HPN (only) OB/GYN Provider Code	Within the past six months have you used tobacco regularly
Child	Last Name	First Name	MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.	Birthdate					
Child	Last Name	First Name	MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.	Birthdate					
Child	Last Name	First Name	MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.	Birthdate					
Child	Last Name	First Name	MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.	Birthdate					
Child	Last Name	First Name	MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.	Birthdate					
Child	Last Name	First Name	MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.	Birthdate					
Child	Last Name	First Name	MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.	Birthdate					

Employee Name: ______________________________________ SSN: ________________________

Relationship					Sex	HPN (only) Primary Care Provider Code	HPN (only) OB/GYN Provider Code	Within the past six months have you used tobacco regularly
Child	Last Name	First Name		MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.		Birthdate					
Child	Last Name	First Name		MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.		Birthdate					
Child	Last Name	First Name		MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.		Birthdate					
Child	Last Name	First Name		MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.		Birthdate					
Child	Last Name	First Name		MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.		Birthdate					
Child	Last Name	First Name		MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.		Birthdate					
Child	Last Name	First Name		MI	☐ M ☐ F			☐ Yes ☐ No
	Social Security No.		Birthdate					

D. Other Medical Coverage Information (This Section D must be completed. Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another HPN and UHC and Affiliates plan or Medicare?

☐ YES (continue completing this Section D) ☐ NO (skip the rest of this Section D) Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (A, B or S)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage

If Other Medical Coverage Has Been Entered It Will Appear on the Previous Page(s)

* A. Enter "A" if this dependent is covered by Another individual (not a member of your household) required to pay for this dependent's medical expenses.
B. Enter "B" if this dependent is covered under Both you and your spouse's insurance plan (married).
S. Enter "S" if you are the Sole parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

If Medicare Information Has Been Entered It Will Appear on the Previous Page(s)

E. Waiver of Coverage (This Section E must be completed and signed if declining medical coverage)

If Waiving Coverage, Information Will Appear on the Following Page(s)

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a Special Enrollment Event or at the next Open Enrollment Period. I also understand that Preexisting Condition Limitations may apply.

Employee Signature	Date

F. Signature (Form must be signed)

I authorize HPN, SHL and/or UHC and Affiliates to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or re-insurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UHC and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UHC and Affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying UHC and Affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the information I authorize a person or entity to obtain and use may be redisclosed and no longer protected by the Federal Privacy Rule. This authorization, unless revoked earlier, shall remain in effect for a period of thirty (30) months from the date signed below. I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself, and, if the plan provides, for my Eligible Family Members. I authorize any required premium contributions to be deducted from earnings. I (we) understand that UHC and Affiliates are not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign this Enrollment Form and before receipt of my identification card. I agree that they shall be used as the basis of acceptance for coverage of me and my Eligible Family Member(s). I acknowledge that I understand each of the questions asked in this form as well as the terms used in those questions. I realize that any material misrepresentation or omission regarding eligibility for coverage may result in rescission of my coverage. I am encouraged to maintain a copy of this authorization for my records.
I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief.

Date	Employee Signature (for self and Eligible Family Members)

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 Nevada Division of Insurance.