HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

UnitedHealthcare®

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, a UnitedHealthcare Company** P.O. Box 15645 Las Vegas, NV 89114-5645 Member Services: (702) 242-7700 or 1-800-888-2264	**UnitedHealthcare Insurance Company** 450 Columbus Boulevard Hartford, CT 06115-0450 Contact Number: 1-877-816-3596
Life Insurance provided by:	**Sierra Health and Life, a UnitedHealthcare Company** Member Services: (702) 242-7700 or 1-800-888-2264	**UnitedHealthcare 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	**UnitedHealthcare 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_____	Employee Type (check all that apply) □ Active □ Hourly □ Salary □ Union □ Non-Union □ Retired □ Other_____ □ COBRA
	Termination □ Voluntary □ Involuntary	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]	Tobacco Use[5]	Email Address
Spouse	Last Name	First Name	MI	☐ M ☐ F			□ Yes □ No	
	Social Security #	Birthdate						
Child	Last Name	First Name	MI	☐ M ☐ F			□ Yes □ No	
	Social Security #	Birthdate						
Child	Last Name	First Name	MI	☐ M ☐ F			□ Yes □ No	
	Social Security #	Birthdate						
Child	Last Name	Last Name	MI	☐ M ☐ F			□ Yes □ No	
	Social Security #	Birthdate						

[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.*
[5] *Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)?*

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		
Check boxes:	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Life /AD&D □ Yes □ No	Supp Life/AD&D □ Yes □ No	Basic Dep Life/ AD&D □ Yes □ No
Plan Name:	_____	_____	_____	_____	_____			

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

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/Dental 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
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

* 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.

Medicare–Employee Information:
If enrolled in Medicare, please attach a copy of the Medicare ID Card.

□ Enrolled in Part A: Effective Date _____
□ Ineligible for Part A □ I chose not to enroll in "Part A".
□ Enrolled in Part B: Effective Date _____
□ Ineligible for Part B □ I chose not to enroll in "Part B".

Reason for Medicare eligibility: □ Over 65 □ Kidney Disease □ Disabled

Medicare – Spouse/dependent Name: _____

□ Enrolled in Part A: Effective Date _____
□ Ineligible for Part A □ Chose not to enroll in "Part A".
□ Enrolled in Part B: Effective Date _____
□ Ineligible for Part B □ Chose not to enroll in "Part B".

Reason for Medicare eligibility: □ Over 65 □ Kidney Disease □ Disabled

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

I decline coverage for:

□ Myself
□ Spouse
□ dependent Children
□ Myself and all Eligible Family Members

I am declining coverage due to other existing medical coverage.
(Please provide a copy of your other existing medical coverage ID Card):

□ Spouse's Employer's Plan
□ Medicare
□ COBRA from Prior Employer
□ Tri-Care
□ Individual Plan □ Other _____
□ Medicaid
□ VA Eligibility
□ I (we) have no other coverage at this time

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 this authorization is voluntary and I may refuse to sign the authorization. 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 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.

_____ (Please initial here) I understand that Nevada requires specific authorization from the applicant agreeing to arbitration. If I am dissatisfied with the findings of an Independent Medical Review, I 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 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.

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