HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

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

2018 Individual Change Form

Section 1: All information must be completed by subscriber

Last Name	First Name	M.I.

Member ID	DOB	SSN	Requested Effective Date

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

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

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

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

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

Section 2: Personal Information

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

Current Name:	New Name:

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 ☐ 90 day wait

Health Plan of Nevada: MyHPN Solutions HMO			Sierra Health and Life: MySHL Solutions		
Bronze HMO	☐ 7 ☐ 10 ☐ 11 ☐ 12		Bronze EPO	☐ 7 ☐ 9	
Silver HMO	☐ 1.1 ☐ 3.1 ☐ 7 ☐ 8 ☐ 9		Silver EPO	☐ 1 ☐ 2 ☐ 6 ☐ 8.1	
			Gold EPO	☐ 7	
Gold HMO	☐ 7		Catastrophic	EPO ☐ 1	PPO ☐ 1
2 Tier	2 Tier Bronze HMO ☐ 1	2 Tier Silver HMO ☐ 1 ☐ 2	Bronze HSA EPO	☐ 2.1 ☐ 3.1	
			Silver HSA EPO	☐ 1.1	

Section 4: Ancillary Coverage[2]

Type of change (check the boxes that apply)

Dental: ☐ Add Coverage ☐ Remove Coverage

☐ PPO Dental ☐ DHMO Dental

Vision: ☐ Add Coverage ☐ Remove Coverage

Section 5: Addition/removal of dependents (NOTE: Use additional sheet if necessary)

☐ **Addition** of dependents ☐ **Removal** of dependents

	Last Name	First Name	MI	DOB	Sex M	Sex F	Dependent SSN (age 5+) Valid NV DL/ID # (age 19+)	Tobacco use[1] Y/N	Other Ins. Coverage
Spouse									☐ Yes ☐ No
Child									☐ Yes ☐ No
Child									☐ Yes ☐ No
Child									☐ Yes ☐ No

Explanation For Change - You must attach documentation to add dependent(s) if other than a 90 day wait.

☐ 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 has the right to adjust premiums for this agreement after providing sixty (60) day notice to the applicant. 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] Mid-year changes from one dental product to the other are not allowed. Members who terminate dental and/or vision mid-year will not be allowed to re-elect until the following open enrollment period.