Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

UnitedHealthcare

Employee Enrollment and Change Form

Effective date:	Group#	Subgroup#	Dept. code	Member#
Employer name				
Employee type: ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-Union ☐ Retired ☐ 1099 (51+ EEs) ☐ Other:				

Please check as appropriate: ☐ Open Enrollment ☐ New Hire ☐ Change ☐ Cobra

☐ New application	☐ Address change	Qualifying Life Event[1]:
☐ Add dependent Event date:	☐ Name change	
☐ Remove dependent Term date:	☐ PCP change	
☐ Terminate coverage Term date:	☐ Other:	Date of Qualifying Event:
☐ Voluntary ☐ Involuntary		COBRA: Start date: End date:

Please print clearly and complete all sections

A. Employee information	☐ Male ☐ Female	Tobacco use[2] ☐ Yes ☐ No	☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Last name	First name	MI	Job title

Primary address (street – not PO Box)	Apt#	City, State	ZIP
Mailing address (if different from above)	**Apt#**	**City, State**	**ZIP**

Home/Cell phone - -	Email address	Date of birth (MM/DD/YY) / /

Social security # (required) - -	Valid Nevada ID #	Date of hire[3] (MM/DD/YY) / /	Hours worked per week

Race (Please choose one option below)		**Ethnicity** (Please choose one option below)	**Preferred Spoken and Written Language** (Please choose one option below)
☐ Two or More Races	☐ White	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ Declined	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Other	☐ Declined	☐ Declined
☐ Black or African American			
☐ Native Hawaiian or Other Pacific Islander			

B. Coverage plan(s) election(s)

SELECT YOUR PLAN BY WRITING IN THE APPROPRIATE BOX BELOW.

- Benefit plans offered are dependent upon your Employer's selection.
- **HPN Plans Only:** 1) 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. 2) Primary Care Provider (PCP) selection is not required for SHL Plans.

HPN HMO/POS Medical Plan Name	SHL Medical Plan Name	Dental Plan Name	Vision Plan Name
PCP name: PCP#: OB/GYN:			

Basic Employee Life/AD&D ☐ Yes ☐ No	Employee Supplemental Life/AD&D ☐ Yes ☐ No
Basic Dependent Life/AD&D ☐ Yes ☐ No	Dependent Supplemental Life/AD&D ☐ Yes ☐ No

Life insurance beneficiary's full name and address	Relationship to employee

[1]Required documentation must be attached. [2]Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)? [3]If the employee is reclassified to full-time status, please provide the date of full-time employment.

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C. Waiver of coverage

- Complete and sign if you are declining Employer offered coverage for you or your Eligible Dependents.

I decline coverage for: ☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren) ☐ Myself and all Eligible Family Members

☐ I (We) have no other coverage at this time.

☐ I (We) am (are) declining coverage due to other existing medical coverage. *NOTE: Required current carrier and policy # must be completed below.

☐ Medicare/Medicaid ☐ VA/Tri-Care ☐ Individual Plan ☐ COBRA ☐ Spouse/Domestic Partner's Employer's Plan

Carrier: _____ **Policy #:** _____

I (We) understand that by waiving coverage at this time, I (we) will not be allowed to participate unless I experience a Qualifying Life Event or at the next Open Enrollment Period.

Employee signature _____ Date _____

D. Dependent coverage

- List Eligible Family Member(s) who are enrolling. You may attach additional sheets if necessary.
- If declining any medical coverage offered to you, your spouse/domestic partner, or your Eligible Family Member(s), you **must** complete the Waiver of Coverage Section C.
- If terming Eligible Family Member(s), list only the members who are terming coverage. You may attach additional sheets if necessary.

	Member information				HPN provider code[4]		Enrolling in
Spouse/D.Partner	Last name / First name / MI		Date of birth		Primary Care Provider	OB/GYN (If applicable)	Medical ☐ Dental ☐ Vision ☐ Term ☐
	Social security # (required) - -	Valid Nevada ID #	Gender ☐ M ☐ F				
	Email address	Tobacco use[2] ☐ Y ☐ N					

Race (Please choose one option below)		Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
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☐ Asian	☐ Other	☐ Declined	☐ Declined
☐ Black or African American			
☐ Native Hawaiian or Other Pacific Islander			

Child 1	Last name / First name / MI		Date of birth		Primary Care Provider	OB/GYN (If applicable)	Medical ☐ Dental ☐ Vision ☐ Term ☐
	Social security # (required) - -	Valid Nevada ID #	Gender ☐ M ☐ F				
	Email address	Tobacco use[2] ☐ Y ☐ N					

Race (Please choose one option below)		Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
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☐ American Indian or Alaska Native	☐ Declined	☐ Not Hispanic/Latino	☐ Non English
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☐ Black or African American			
☐ Native Hawaiian or Other Pacific Islander			

[4]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; SHL Plans=not required. Females may choose one medical care PCP and one OBGYN.

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Child 2

Last name	First name	MI	Date of birth	Primary Care Provider	OB/GYN (If applicable)	
						Medical ☐
Social security # (required) - -	Valid Nevada ID #		Gender ☐ M ☐ F			Dental ☐ Vision ☐ Term ☐
Email address		Tobacco use[2] ☐ Y ☐ N				

Race (Please choose one option below)		**Ethnicity** (Please choose one option below)	**Preferred Spoken and Written Language** (Please choose one option below)
☐ Two or More Races	☐ White	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ Declined	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Other	☐ Declined	☐ Declined
☐ Black or African American			
☐ Native Hawaiian or Other Pacific Islander			

Child 3

Last name	First name	MI	Date of birth	Primary Care Provider	OB/GYN (If applicable)	
						Medical ☐
Social security # (required) - -	Valid Nevada ID #		Gender ☐ M ☐ F			Dental ☐ Vision ☐ Term ☐
Email address		Tobacco use[2] ☐ Y ☐ N				

Race (Please choose one option below)		**Ethnicity** (Please choose one option below)	**Preferred Spoken and Written Language** (Please choose one option below)
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☐ American Indian or Alaska Native	☐ Declined	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Other	☐ Declined	☐ Declined
☐ Black or African American			
☐ Native Hawaiian or Other Pacific Islander			

Child 4

Last name	First name	MI	Date of birth	Primary Care Provider	OB/GYN (If applicable)	
						Medical ☐
Social security # (required) - -	Valid Nevada ID #		Gender ☐ M ☐ F			Dental ☐ Vision ☐ Term ☐
Email address		Tobacco use[2] ☐ Y ☐ N				

Race (Please choose one option below)		**Ethnicity** (Please choose one option below)	**Preferred Spoken and Written Language** (Please choose one option below)
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If you are providing additional sheets, check ☐ here and insert the sheets before submitting this Enrollment form.

[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]DHMO products are underwritten by Nevada Pacific Dental.

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E. Other medical coverage information

- Section E must be completed if applicable.
- You may attach additional sheets if necessary.

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

☐ Yes (continue completing this section) Name of other carrier:_____

☐ No (skip this section) Policy #:_____

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/Domestic partner name				
Dependent name				
Dependent name				
Dependent name				
Dependent name				

* Enter "A" if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expense.
Enter "B" if this dependent is covered under both you and your spouse/domestic partner's insurance plan (married).
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:

_____

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

Terms and Conditions – Please read carefully before signing Section F

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.
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 and/or work in HPN's Service Area (except under certain circumstances specifically negotiated by Employer).
7. DHMO products are underwritten or provided by Nevada Pacific Dental.

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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.

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. Information from medical records and information received from Physicians or Hospitals incident to the Physician/Patient relationship or Hospital/Patient relationship shall be kept confidential and except for use in connection with government requirements established by law or the administration of this Plan, records may not be disclosed to any unrelated third party without the Applicant's consent. 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 I am completing a joint life and health application and that each response must be complete and accurate. I request the indicated group medical coverage for myself, and, if the plan provides, for my Eligible Family Member(s). I authorize any required premium contributions to be deducted from earnings. I understand UHC and Affiliates are not bound by any statements I 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 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 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.

☐ (Please check here) I understand that the Certificate of Coverage and other documents, notices and communications regarding my health benefit plan may be transmitted electronically and I confirm that I routinely use electronic communications. This consent remains in effect until it is withdrawn. I may withdraw my consent at any time or request a document in a paper or non-electronic form.

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief.

Employee signature (for self and Eligible Family Member(s))	Date
Employer 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 Nevada Division of Insurance.