

➔ It's easy to enroll with Health Plan of Nevada

Follow these simple instructions below:

1. Please detach and complete the Health Plan of Nevada Individual HMO or POS Enrollment Application, Individual Medical Questionnaire and Applicant Authorization Form provided in the enclosed booklet. Make sure that all information is complete and accurate. Be sure to indicate which plan you wish to enroll in, and 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 with the appropriate premium for the plan you select. You have the option of making a monthly payment directly to Health Plan of Nevada 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 authorization agreement for pre-arranged payments, and enclose a voided check. If you elect direct billing, you will be charged a \$10 fee each month.
4. **Return the Individual Enrollment Application, Individual Medical Questionnaire, Applicant Authorization Form and your payment** to Health Plan of Nevada in the enclosed, self-addressed envelope.
5. **Our Medical Underwriting Department** will contact you 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 Agreement of Coverage, 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



Please type or print in BLACK INK - An Individual Medical Questionnaire must be completed for each applicant. ALL QUESTIONS MUST BE ANSWERED

Completion of the Individual Medical Questionnaire is required for: (1) Coverage on self; (2) Coverage on spouse; (3) Coverage on any eligible dependent child if application is made more than thirty-one (31) days after acquiring child; (4) Coverage which was previously waived, declined, terminated on an Eligible Family Member; and (5) Any increase in benefits.

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 for further instructions regarding your application for coverage.

Table with 10 columns: Applicant Number, Last Name, First Name, MI, Sex, Date of Birth, Height, Weight, Birthplace, Current Physician Address. Rows include Self, Spouse, and multiple Child entries.

PART I PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Do you currently have, or has anyone applying for coverage had prior healthcare coverage in the past twelve (12) months? Yes No

If yes, name of Member/Insured: _____

Name of HMO/Insurance Carrier: _____

a) Was coverage provided by an: HMO Group Policy Individual Policy

b) Effective Date: ___/___/___ c) Termination Date: ___/___/___ Reason for Termination: _____

If the termination date of prior healthcare coverage is within sixty-three (63) days of the date the Individual Medical Questionnaire is signed, please attach the Certificate of Creditable Coverage. (This is mandatory for persons applying for the HIPAA Standard or Basic Plans.)

d) If this application is accepted, do you agree to discontinue your current coverage? Yes No

e) Are you or any Eligible Family Member currently enrolled on COBRA? Yes No

If yes, Termination Date: ___/___/___

2. Is either the applicant, spouse, or any female Eligible Family Member(s), whether or not listed on the application currently pregnant? Yes No

Please note: Coverage under HPN's Individual Plans cannot be issued if you, your spouse, or any female Eligible Family Member (including a dependent child) is now pregnant, unless the pregnant individual is considered HIPAA eligible (See Individual PPO Enrollment Application).

3. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on this application? Yes No

4. Has anyone applying for healthcare coverage smoked or used any form of a tobacco product within the past twelve (12) months including, but not limited to the following: cigarettes, pipe, cigar, snuff, or chewing tobacco? Yes No

If yes, who? _____

a) Pack(s) per day? ___ b) How many years? ___ c) When did he/she stop the tobacco product use? ___/___/___

5. Has anyone applying for healthcare coverage consumed alcoholic beverages in any form within the past five (5) years? Yes No

If yes, who? _____

Please indicate the number of drinks consumed: ___ Daily ___ Weekly ___ Monthly

(1 drink = 12 oz beer; 4 oz wine; 2 oz liquor)

INDIVIDUAL MEDICAL QUESTIONNAIRE

6. Within the past five (5) years, has anyone applying for coverage had treatment for, been arrested for, or used any drug which was not prescribed by a physician such as amphetamines or other stimulants, barbiturates or other depressants, cocaine, heroin or other narcotics, LSD or other hallucinogens, marijuana, hashish or tranquilizers? Yes No
7. Has anyone applying for coverage ever had his/her driver's license suspended or revoked for driving while intoxicated, or ever been convicted of a felony? Yes No

PART II **HEALTH HISTORY OF YOU AND YOUR FAMILY** **(Include information on ALL Eligible Family Members you wish to cover.)**

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? **For each "YES" answer, details must be given in question #23. (All questions must be answered.)**

1. Heart/Circulatory System – aneurysm, arteriosclerosis, chest pain, coronary heart disease, elevated cholesterol, heart attack, heart murmur, high or low blood pressure, palpitations, pacemaker, phlebitis, stroke, transient ischemic attacks (TIA), varicose veins, or any other disease or disorder of the heart/circulatory system? Yes No
2. Lungs/Respiratory System – allergies, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), difficulty breathing, emphysema, hay fever, pleurisy, pneumonia, pneumothorax, pulmonary embolism, pulmonary tuberculosis, shortness of breath, sinusitis, or any other disease or disorder of the lungs/respiratory system? Yes No
3. Brain/Nervous System – Bell's palsy, cerebral palsy, dizziness, epilepsy (convulsions and seizures), fainting spells, mental retardation, migraine headaches, multiple sclerosis, narcolepsy, paralysis, Parkinson's disease, stroke, or any other disease or disorder of brain/circulatory system? Yes No
If epileptic: date of last seizure _____
4. Digestive System – cirrhosis, colitis, diarrhea, diverticulitis, fatty liver, gallbladder disease, gastric bypass surgery, gastroesophageal reflux disease (GERD), gastritis, hemorrhoids, hepatitis, hiatal hernia, inflammatory bowel diseases (Crohn's disease, Ulcerative colitis), intestinal problems, pancreatitis, rectal problems, ulcers, or any other disease or disorder of the esophagus, stomach, intestines or liver? Yes No
5. Genitourinary System – albuminuria, amenorrhea, cervical dysplasia, cervicitis, cystitis, dysmenorrhea, endometriosis, fibroid tumor, hematuria, hysterectomy, kidney stone, menorrhagia, nephritis, renal failure, renal transplant, urinary incontinence, urinary tract infections, or any other disease or disorder of the urinary system? Yes No
6. Skeletal and Muscular System – arthritis, back sprain/strain, bursitis, carpal tunnel syndrome, collagen vascular diseases (connective tissue diseases), fractures, gout, hip disorders, knee disorders, osteoporosis, or any other injury, disease or disorder of the joints, muscles or bones? Yes No
7. Nervous and Mental Disorders – alzheimer's, anxiety, anorexia, attention deficit disorder, behavioral problems, bipolar, bulimia, chemical imbalance, depression, eating disorder, emotional problems, or any other nervous and mental disorders? Yes No
8. Endocrine/Metabolic System – AIDS or AIDS-Related Complex, anemia, adrenal disorders, diabetes, immune disorders, lupus, Raynaud's, thyroid or any other endocrine/metabolic disease or disorder? Yes No
9. Male Reproductive System – disorders of the penis and scrotum, erectile dysfunction, genital herpes, genital warts, gonorrhea, impotency, infertility, prostate, urinary tract infections, sexually transmitted disease (STD), syphilis, or any other male genital disease or disorder? Yes No
10. Female Reproductive System – abnormal menstrual bleeding, abortion-miscarriage, breast disorder/cyst, endometriosis, fibroid tumors, genital herpes, genital warts, gonorrhea, infertility, menstruation disorders, ovarian cysts, pelvic pain, sexually transmitted disease (STD), syphilis, or any other female genital disease or disorder? Yes No
11. Has anyone applying for healthcare coverage been diagnosed with or treated for cancer, cyst, growth, leukemia, tumors (malignant or benign)? Yes No
12. Has anyone applying for healthcare coverage been diagnosed with or treated for cataract, glaucoma, or any other eye disease or disorder? Yes No
13. Has anyone applying for healthcare coverage been diagnosed with any physical deformity, birth defect, congenital problems or impairment? Yes No
14. Has anyone applying for healthcare coverage been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same? Yes No
15. Has anyone applying for healthcare coverage been a patient of any hospital, clinic or other medical facility in the past five (5) years? Yes No

INDIVIDUAL MEDICAL QUESTIONNAIRE

By signing this document:

- I understand that Health Plan of Nevada, Inc. (HPN) will acknowledge my application for healthcare coverage with a **verification telephone call**. It is my understanding that this verification call is a routine process for those applying for coverage with HPN and that this telephone call will be recorded. I also understand that my application will not be given further consideration if verification is not completed. I may be contacted at the following number, **between 8:00 a.m. - 4:30 p.m.**:

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 ()

My spouse (if applying for coverage) may be contacted at the following telephone number:

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

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

- I represent that all statements and answers made in this document, by whomsoever written including its reverse side and on any attached papers, are true and complete to the best of my knowledge and belief. I agree that this shall be the basis of my acceptance or membership. I realize that any misrepresentation or omission, for any reason, regarding the presence of Preexisting Conditions may result in rescission of my coverage.
- I understand that I am entitled to a copy of this form. Notification of acceptance or rejection of my application will be sent to me by HPN. When the application is accepted, the Effective Date will be indicated.
- I understand that there are Preexisting Condition limitations and waiting periods for certain conditions, except for a guaranteed issue policy under HIPAA. I understand that my coverage and the coverage of my Eligible Family Members may be subject to those exclusions and waiting periods.
- I understand that any omissions or false statements on this Individual Medical Questionnaire may cause an otherwise valid claim to be denied and/or termination of my healthcare coverage or my family's healthcare coverage. If issued, such termination may be made retroactive to the original Effective Date.
- I understand that this form may become a part of my medical records.

I (WE) understand and accept this agreement.

Applicant/Guardian Signature: _____ **Date:** ____/____/____

Spouse Signature: _____ **Date:** ____/____/____

Eligible child's Signature (18 years and over): _____ **Date:** ____/____/____

Eligible child's Signature (18 years 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



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

APPLICANT AUTHORIZATION FORM
(This form is required for new applicants only)

Health Plan of Nevada conditions enrollment on completion of this authorization. You must complete and return this authorization form as part of your application for health coverage.

I hereby authorize any hospital, clinic, institution, physician, or other health care provider to disclose the entire medical record of any Applicant listed herein to the recipient named 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.

The recipient of the information is Health Plan of Nevada, Inc. 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 signed below.

Please list the name of the applicant and all dependents applying for coverage in the spaces below.

_____	_____
Applicant (Print Name)	Dependent #4 (Print Name)
_____	_____
Dependent #1 (Print Name)	Dependent #5 (Print Name)
_____	_____
Dependent #2 (Print Name)	Dependent #6 (Print Name)
_____	_____
Dependent #3 (Print Name)	Dependent #7 (Print Name)

Applicant Signature: _____ Date of Birth: ____ - ____ - ____ Date: _____
Applicant is acting as the personal representative for all dependents listed above.

OR

Signature of Applicant’s legally authorized representative (signers other than the applicant must present legal documentation that authorizes them to act on the applicant’s behalf)

_____ Date: _____
Applicant’s Representative Signature

_____ Relationship to applicant
Printed name of applicant’s representative

The information you authorize to be disclosed may be re-disclosed by the recipient 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. Attn. Medical Underwriting Dept., P. O. Box 15645, Las Vegas, NV 89114-5645.

This authorization is voluntary and you may refuse to sign this authorization. However, your failure to complete and return this authorization form will either result in a higher premium rate or prevent us from offering health insurance to you.



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

**INDIVIDUAL HMO
DEPENDENT CHILD FORM**

IF YOU ARE APPLYING FOR COVERAGE FOR AN ELIGIBLE DEPENDENT CHILD/CHILDREN ONLY, PLEASE COMPLETE THE INFORMATION REQUESTED BELOW.

I, _____, agree to be responsible for the payment of all premiums/refunds due in connection with coverage provided on behalf of the eligible Dependent child/children listed below under the Individual HMO Plan underwritten by Health Plan of Nevada, Inc.

1. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____

Signature of Parent or Court Appointed Legal Guardian

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.



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

P.O. Box 15645
Las Vegas, Nevada 89114-5645

**Mandatory Offer Form
Individual Autism Spectrum Disorder Rider**

Subject to applicable Nevada law, as a policyholder of an individual health benefit plan underwritten by Health Plan of Nevada, Inc. (“HPN”) or Sierra Health and Life Insurance Company, Inc. (“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). An eligible dependent child is 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 Individual ASD Rider for each eligible dependent child who is currently enrolled or whom you intend to enroll under your health benefit plan.

Please indicate your selection below:

Individual Autism Spectrum Disorder Rider

- Effective upon your Health Benefit Plan’s first Effective Date of coverage or renewal Effective Date beginning January 1, 2011, and upon your acceptance of the Individual ASD Rider for each specific eligible dependent child, benefits for Covered Services for the treatment of ASD will be payable to the same extent as benefits for any other Illness or Injury under the Health Benefit Plan, except that treatment for Applied Behavioral Analysis is limited to \$36,000 per enrolled dependent child per year.

Eligible Dependent Child’s Name*	Election	
1. _____	<input type="checkbox"/> Accept	<input type="checkbox"/> Decline
2. _____	<input type="checkbox"/> Accept	<input type="checkbox"/> Decline
3. _____	<input type="checkbox"/> Accept	<input type="checkbox"/> Decline
4. _____	<input type="checkbox"/> Accept	<input type="checkbox"/> Decline
5. _____	<input type="checkbox"/> Accept	<input type="checkbox"/> Decline

*Please fill out the numbered Eligible Dependent Child’s Name section above in the same numerical order that you fill out the Individual Enrollment Form. **Failure to complete and return this form in the required timeframe will result in automatic declination of this coverage.**

I, the undersigned, understand and agree that this application is for the health care coverage offered by Health Plan of Nevada, Inc. (“HPN”), or Sierra Health and Life Insurance Company, Inc. (“SHL”), and will form a part of any Agreement issued in reliance upon it. Acceptance of the coverage and the final rates are based upon the above information. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact therein, will permit HPN and/or SHL to rescind such coverage. I acknowledge that my Representative has

Mandatory Offer Form – Individual Autism Spectrum Disorder Rider

explained the coverages, limitations and exclusions, and other details of the Individual coverage for which I applied. Once selected, the Individual ASD Rider shall terminate upon termination of the Agreement under the same terms and conditions specified therein.

It is also understood that any existing coverage presently being provided should not be canceled until written approval of this application has been received. A one-month deposit is being submitted, to be held without obligation until this application is approved. If the application is approved, the deposit will be applied to the first month's premium under this Agreement. If coverage does not become effective, the deposit will be refunded.

Individual Applicant's Signature _____ Date _____

HEALTH PLAN OF NEVADA PREMIUM TABLE AUTISM RIDER	
Attained Age	ASD Monthly Premium (if Rider elected)
Under Age 1	\$67.00
Age 1 to 2	\$836.00
Age 2 to 3	\$1,672.00
Age 3 and Over	\$3,345.00

SIERRA HEALTH AND LIFE PREMIUM TABLE AUTISM RIDER	
Attained Age	ASD Monthly Premium (if Rider elected)
Under Age 1	\$80.00
Age 1 to 2	\$1,002.00
Age 2 to 3	\$2,004.00
Age 3 and Over	\$4,009.00

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.