

HEALTH PLAN OF NEVADA, INC.SM
a subsidiary of Sierra Health Services, Inc.[®]

INDIVIDUAL DISTINCT ADVANTAGE – 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 Distinct Advantage 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.