

**HEALTH PLAN OF NEVADA, INC.<sup>SM</sup>**  
a subsidiary of Sierra Health Services, Inc.<sup>SC</sup>

**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.