SINCE 1982

HEALTH PLAN OF NEVADA, INC.

a subsidiary of Sierra Health Services, Inc.

Area for HPN use only:
Declined ☐ Accepted ☐ Effective Date: _____/_____/_____
Date Processed _____/____/______ Underwriter_______________________

Individual HMO Enrollment Application Form

☐ Direct Bill ☐ Sure Pay (AutoPay)

Please mark your selection.	☐ **Option 1 (HMO)** *12-month MWP	☐ **Option 2 (HMO)** *No Maternity Coverage	☐ **Option 3 (POS)** * 12-month MWP	☐ **Option 4 (HMO)** *No Maternity Coverage	**Dental**: ____ Yes ____ No Optional for **all** Individual Plans	**Vision:** ____Yes ____No

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed Date of Marriage:____________

Applicant Name: ____________________________________ Social Security No. ______________________

Street Address:____
Street Apt # City State/Zip County

Billing Address: (If different than above)____

Home Phone: (___)______________________Email Address: ______________________________

Business Phone: (____) ______________________ Occupation:______________________________

Employer Name/Address:____
Name Street Apt # City State/Zip

Emergency Contact Name:________________________________Phone Number: (____)____________

HIPAA Plans:
___ **Standard** ___**Basic**

I have attached proof that I meet the following HIPAA eligibility requirements:

1. My HIPAA qualifying event occurred no more than sixty-three (63) days prior to the date of this application;
2. Most recent healthcare coverage was under a Group Plan;
3. Have a minimum aggregate period of eighteen (18) months of Creditable Coverage;
4. Exhausted COBRA or similar continuation of coverage, if applicable;
5. Not covered by other healthcare coverage;
6. Do not qualify for Medicare or Medicaid;
7. Did not have Group healthcare coverage terminated for fraud or non-payment of premiums.

PLEASE LIST YOURSELF AND ALL ELIGIBLE FAMILY MEMBERS APPLYING FOR COVERAGE. Only your spouse and Eligible Family Member(s) under the age of 24 may apply except that those children between the ages of 19 and 24 are not eligible as Dependents unless they are full-time students and unmarried. If your child does not qualify as an Eligible Family Member, he/she may apply for his/her own Individual healthcare coverage.

THIS SECTION MUST BE COMPLETED

Last Name	First Name	MI	Sex M or F	Relationship to Applicant	Birthdate	SS#	HPN Primary Care Physician*	HPN OB/GYN (For Females)*	ESD#
				Applicant					

*** SELECT A PHYSICIAN CODE FROM THE HPN PROVIDER DIRECTORY INCLUDED IN YOUR ENROLLMENT PACKAGE. FEMALES SHOULD ALSO SELECT AN OB/GYN PHYSICIAN.**

Health Plan of Nevada, Inc., ("HPN") has the right to increase premiums for this Agreement after providing sixty (60) days notice to the Applicant. Any such increase will apply to all Members in the same class. In addition, an increase will be applied if a Member has a birthday that results in an age reclassification on the rate charts. Applications are subject to medical underwriting which may result in an increase in premium or rejection of application unless the Applicant qualifies for a HIPAA policy according to Nevada state law.

I hereby apply to HPN for coverage now being offered to my Eligible Family Member(s) and me, if any, as shown above. I understand that this application is subject to acceptance by HPN and that if an Agreement is issued, services will be available subject to the terms, exclusions, limitations and benefits described in the HPN Agreement of Coverage (AOC) and the applicable Attachment A, Benefit Schedule.

I hereby certify that me and my Eligible Family Member(s) are not eligible for Medicare and, (**Please check one box**), ☐ do not have other healthcare coverage; or ☐ have coverage with (Carrier):________________________________ which will be terminated when this Plan is made effective. If the other healthcare coverage is not terminated, or other healthcare coverage is obtained, then HPN shall have the right to term coverage retroactively to the original Effective Date and refund any corresponding premium.

If the application is declined or if the Member is not satisfied and within ten (10) days of actually receiving the AOC, the Applicant may request a full refund of the premium paid. **Conditions of Application:**
It is important that you carefully read and fully understand the following: All Applicants age 18 and over must personally read, agree to, and sign below.

EFFECTIVE DATE

If HPN approves my application, please request an Effective Date of the: ☐ 1st of (month) __________________ ☐ 15th of (month) ______________
The Effective Date must be after the signature date, but not greater than forty-five (45) days from the signature date on this Individual HMO Enrollment Application.

The requested Effective Date is subject to change. If your Individual Enrollment Application is approved for issue, your Effective Date will be communicated to you by HPN's Underwriting department via a confirmation of coverage letter. I understand that once the Individual HMO Enrollment Application is approved and the policy issued, HPN cannot change the established Effective Date.

Note: If you are adding an Eligible Family Member, the Effective Date will always be the first (1st) day of the calendar month following the month when the Individual HMO Plan Change Request Form is received and approved by HPN.

Applicant/GuardianSignature:____**Date:**____________________

Spouse Signature:____**Date:**____________________

Family Member's Signature (18 yrs and over)_________________________________**Date:**____________________

Family Member's Signature (18 yrs and over)_________________________________**Date:**____________________

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an HMO or 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 HMO or insurance company or agent of an HMO or 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 HMO or insurance proceeds shall be reported to the Division of Insurance.

INITIAL PAYMENT ONLY – OPTIONAL CREDIT CARD PREMIUM PAYMENT

You may choose to make your initial premium payment by check, money order or credit card. Credit card payment is available for your first premium payment only. All subsequent payments will be made through monthly bills. If choosing to pay by credit card, you must complete all of the following information:

☐VISA ☐Master Card ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐-☐☐☐☐ $______________

Credit Card # Exp Date: (mm/yyyy) Max Premium Amount Authorized

I authorize HPN to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	Cardholder Signature:	Date

AGENT INFORMATION

Tax ID #_____________________Phone #: ____________________ Agency:__________________________Agent:______________________________

Street Address: ______________________________ City/State/Zip:___________________________Agent's Signature__________________ Date:________