



**SIERRA HEALTH AND LIFE
INSURANCE COMPANY, INC.[®]**
a subsidiary of Sierra Health Services, Inc.[®]

**INDIVIDUAL PPO (“IPPO”)
DEPENDENT CHILD FORM**

**IF YOU ARE APPLYING FOR COVERAGE FOR A DEPENDENT CHILD/CHILDREN ONLY,
PLEASE COMPLETE 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 dependent(s) listed below under the IPPO Plan underwritten by Sierra Health and Life Insurance Company, Inc.

- 1. _____
- 2. _____
- 3. _____
- 4. _____

- 5. _____
- 6. _____
- 7. _____
- 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.