HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

UnitedHealthcare®

Employee Enrollment and Change Form

Grp #	Mbr #

Employer Name	Dept. Code

Employee Type: ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-Union ☐ Retired ☐ Other: _____

Please check as appropriate: ☐ Annual Open Enrollment ☐ New Hire ☐ Change ☐ Cobra

☐ New Application	Effective Date:	☐ Address Change	Qualifying Life Event[1]:
☐ Add Dependent	Event Date:	☐ Name Change	
☐ Remove Dependent	Term Date:	☐ PCP Change	
☐ Terminate Coverage	Term Date:	☐ Other:	Date of Qualifying Event:
☐ Voluntary ☐ Involuntary			COBRA: Start Date:_____ End Date: _____

Please Print Clearly and Complete All Sections.

A. Employee Information

- Please complete information requested

Name (Last, First, Middle Initial)			☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed
Address (Street)	Apt #	City, State	Zip

Job Title	Date of Hire[2] (Mo/Day/Yr)	Hours Worked per Week	Home/Cell Phone	Work Phone

B. Waiver of Coverage

- This section must be completed and signed if you are declining any Employer offered coverage for you, your spouse/domestic partner or your Eligible Family Member(s).

I decline coverage for: ☐ Myself ☐ Spouse/Domestic Partner ☐ Child(ren) ☐ Myself and all Eligible Family Members

Please indicate reason for declining coverage:

☐ Medicare/Medicaid	☐ Tri-Care	☐ VA Eligibility	☐ Spouse/Domestic Partner's Employer's Plan
☐ Individual Plan	☐ COBRA	☐ Other: _____	☐ I (we) have no other coverage at this time

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a Qualifying Life Event or at the next Open Enrollment Period.

Employee Signature	Date

C. Coverage Selection

- Benefit plans offered are dependent upon your Employer's selection.
- Complete the Life Insurance Beneficiary's information requested if your employer offers this benefit.
- **HPN Plans Only:** 1) Primary Care Physician (PCP) selection is not required for HPN Open Access or SHL Plans. 2) Select a PCP from the HPN Provider Directory for you and each of your Eligible Family Member(s) by filling in the PCP name and corresponding Provider number. You may choose a different PCP for each member in your family.
- **HPN Direct Solutions Plans Only:** Southwest Medical Associates (SMA) PCP for primary care only. Pediatric and OBGYN access to full HPN network.

	HPN HMO Medical	HPN POS Medical	SHL PPO/HSA Medical	Dental[5]	Vision
Plan Name:					

Basic Employee Life/ AD&D: ☐ Yes ☐ No	Employee Supplemental Life/AD&D: ☐ Yes ☐ No
Basic Dependent Life/AD&D: ☐ Yes ☐ No	Dependent Supplemental Life/AD&D: ☐ Yes ☐ No
Life Insurance Beneficiary's Full Name and Address	Relationship to the Employee

[1]Legal documentation must be attached. [2]If the employee is reclassified to full-time status, please provide the date of full-time employment. [3]If declining any medical coverage offered to you or your Eligible Family Member(s); you must complete the Waiver of Coverage Section. [4]Refer to the HPN Primary Care Provider (PCP) Directory. Enter the number found next to the Provider you choose as a PCP. PCP Selection: HPN HMO & POS Plans=required; HPN Open Access Plans=not required, but recommended; SHL Plans=not required. Females may choose one medical care PCP and one OBGYN. [5]DHMO products are underwritten or provided by Nevada Pacific Dental.

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D. Individuals Covered[3]

- List Eligible Family Member(s) who are enrolling. You may attach additional sheets if necessary.
- If declining any medical coverage offered to you, your spouse/domestic partner, or your Eligible Family Member(s), you must complete the Waiver of Coverage Section B.

	Member Information		HPN Provider Code[4]		Please check if enrolling in coverage for		
#1 Employee	Name (Last, First, MI)	Birthdate	Primary Care	OBGYN (If Applicable)	Medical	Dental	Vision
	Social Security #	Gender ☐M ☐F			☐	☐	☐
	Email Address	Tobacco Use[6] ☐Y ☐N					
#2 Spouse/D. Partner	Name (Last, First, MI)	Birthdate	Primary Care	OBGYN (If Applicable)	Medical	Dental	Vision
	Social Security #	Gender ☐M ☐F			☐	☐	☐
	Email Address	Tobacco Use ☐Y ☐N					
#3 Dependent	Name (Last, First, MI)	Birthdate	Primary Care	OBGYN (If Applicable)	Medical	Dental	Vision
	Social Security #	Gender ☐M ☐F			☐	☐	☐
	Email Address	Tobacco Use ☐Y ☐N					
#4 Dependent	Name (Last, First, MI)	Birthdate	Primary Care	OBGYN (If Applicable)	Medical	Dental	Vision
	Social Security #	Gender ☐M ☐F			☐	☐	☐
	Email Address	Tobacco Use ☐Y ☐N					
#5 Dependent	Name (Last, First, MI)	Birthdate	Primary Care	OBGYN (If Applicable)	Medical	Dental	Vision
	Social Security #	Gender ☐M ☐F			☐	☐	☐
	Email Address	Tobacco Use ☐Y ☐N					
#6 Dependent	Name (Last, First, MI)	Birthdate	Primary Care	OBGYN (If Applicable)	Medical	Dental	Vision
	Social Security #	Gender ☐M ☐F			☐	☐	☐
	Email Address	Tobacco Use ☐Y ☐N					

If you are providing additional sheets, check here ☐ and insert the sheets before submitting this Enrollment form.

[3]If declining any medical coverage offered to you or your Eligible Family Member(s); you must complete the Waiver of Coverage Section. [4]Refer to the HPN Primary Care Provider (PCP) Directory. Enter the number found next to the Provider you choose as a PCP. PCP Selection: HPN HMO & POS Plans=required; HPN Open Access Plans=not required, but recommended; SHL Plans=not required. Females may choose one medical care PCP and one OBGYN. [6]Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)?

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E. Other Medical Coverage Information

- Section D must be completed if applicable.
- You may attach additional sheets if necessary.

On the day this coverage begins, will you, your spouse/domestic partner or any of your dependents be covered under any other medical health/dental plan or policy, including another HPN or UHC Affiliate plan or Medicare?

☐ Yes (continue completing this section) Name of other carrier:_____ ☐ No (skip this section)

Other Group Medical Coverage Information (only list those covered by other plan)	Type (A, B or S)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse/Domestic Partner Name				
Dependent Name				
Dependent Name				
Dependent Name				
Dependent Name				

* Enter "A" if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expense.
Enter "B" if this dependent is covered under both you and your spouse/domestic partner's insurance plan (married).
Enter "S" if you are the sole parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

Medicare-Employee Information: If enrolled in Medicare, please attach a copy of the Medicare ID Card.	Medicare-Spouse/Dependent Name:_____ If enrolled in Medicare, please attach a copy of the Medicare ID Card.
☐ Enrolled in Part A: Effective Date:_____ ☐ Ineligible for Part A ☐ I chose not to enroll in "Part A" ☐ Enrolled in Part B: Effective Date:_____ ☐ Ineligible for Part B ☐ I chose not to enroll in "Part B"	☐ Enrolled in Part A: Effective Date:_____ ☐ Ineligible for Part A ☐ I chose not to enroll in "Part A" ☐ Enrolled in Part B: Effective Date:_____ ☐ Ineligible for Part B ☐ I chose not to enroll in "Part B"
Reason for Medicare eligibility ☐ Over 65 ☐ Kidney Disease ☐ Disabled	Reason for Medicare eligibility ☐ Over 65 ☐ Kidney Disease ☐ Disabled

Terms and Conditions – Please read carefully before signing Section F

I hereby apply for medical benefit coverage offered through my Employer and underwritten by Health Plan of Nevada ("HPN" or Sierra Health and Life ("SHL"), UnitedHealthcare Companies and ancillary products underwritten by HPN, SHL and/or UnitedHealthcare and its affiliates ("UHC and affiliates") for my Eligible Family Member(s) and myself. I agree to and understand the following:

1. To be bound by the Group Enrollment Agreement ("Agreement") signed by my Employer and UHC and Affiliates.
2. My Employer may deduct from my earnings; the employee contribution required to cover my share of the premium, if any.
3. UHC and Affiliates or a designee may access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, billing, payment or healthcare operations of the Agreement or Plan.
4. Any incomplete or incorrect material omission or misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my and/or my Eligible Family Member(s) membership in a healthcare Plan with UHC and Affiliates.
5. Coverage shall not begin until acceptance of this signed Enrollment Form and any applicable premiums have been received and accepted by UHC and Affiliates. Upon acceptance of this Enrollment Form and premium, UHC and Affiliates shall be bound by the terms of the Agreement or Plan and any Amendments thereto.
6. If enrolling in an HMO or POS medical plan underwritten by HPN, my Eligible Family Member(s) and I must live or work in HPN's Service Area (except under certain circumstances specifically negotiated by Employer).

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F. Signature

- Section F must be signed and dated by the Employee
- Your signature indicates that you have read, understand and agree to the terms and conditions of coverage provided through your Employer. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

I authorize HPN, SHL and/or UHC and Affiliates to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or re-insurer, hospital, clinic or other medical facility, health care clearinghouse and any of their affiliates, representatives or business associates, to disclose my information to UHC and Affiliates. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying UHC and Affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization. I further understand the information I authorize a person or entity to obtain and use may be redisclosed and no longer protected by the Federal Privacy Rule. This authorization, unless revoked earlier, shall remain in effect for a period of thirty (30) months from the date signed below.

I understand that I am completing a joint life and health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself, and, if the plan provides, for my Eligible Family Member(s). I authorize any required premium contributions to be deducted from earnings. I (we) understand that UHC and Affiliates are not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. I acknowledge that I understand each of the questions asked in this form as well as the terms used in those questions. I realize that any material misrepresentation or omission regarding eligibility for coverage may result in rescission of my coverage. I am encouraged to maintain a copy of this authorization for my records.

_____ (**Please initial here**) I understand that Nevada requires specific authorization from the applicant agreeing to arbitration. If I am dissatisfied with the findings of an Independent Medical Review, I shall have the right to have the dispute submitted to binding arbitration before an arbiter under the commercial arbitration rules applied by the American Arbitration Association.

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief.

Employee Signature (for self and Eligible Family Member(s))	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 Nevada Division of Insurance.