SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Area for SHL use only:

☐ Declined ☐ Accepted Effective Date: _____/_____/_____
Date Processed _____/____/______ Underwriter_________________
SHL Rep:____

INDIVIDUAL PPO PLAN CHANGE REQUEST FORM

THIS IS A REQUEST TO: ☐ **Change Coverage** ☐ **Add Dependent(s)**

INSURED'S INFORMATION

Full Name: ______________________________________ Date of Birth: ____ /____ /____ SS#:___________________

Member Phone#: (_____)____________________ E-mail ____

Complete Address: ____

TO CHANGE COVERAGE

Please mark Plan Option requested:

Distinct Advantage: ☐ **Plan 1 1000(35) - 85** ☐ **Plan 2 1500(35) - 86** ☐ **Plan 3 2500(40) – 97** ☐ **Plan 4 5000(50) - 86**
SS Plans: ☐ **Plan A 1500(80/60)** ☐ **Plan B 2500(100/70)** ☐ **Plan C 2500(80/60)** ☐ **Plan D 5000(100/70)**
☐ **IPPO Standard** ☐ **IPPO Basic** **Other:** ____

Note: If you are requesting a change to a Plan option with a higher level of benefits, you must complete the Sierra Health and Life Insurance Company, Inc. ("SHL") Individual Medical Questionnaire Form in order for your request to be processed. If you need an SHL Individual Medical Questionnaire Form, please contact your Agent or SHL.

TO ADD ELIGIBLE FAMILY MEMBER

☐ **Spouse**
Date of Marriage: ____ / ____ / ____ Name: ______________________________ Date of Birth: ___ / ____ / ____ Sex: ____
SS# ______________ Birthplace: __________ Daytime phone: _____________ Height ____ (ft) ____ (in) Weight: ___ (lbs)

☐ **Child**
Date child acquired: ____/____/____ Full Name: ____ Sex: ____
Relationship _________________________ Date of Birth: ____ / ____ / ____ Height _____ (ft) _____ (in) Weight: ___(lbs)

NOTE: Coverage for an eligible Dependent child is subject to satisfactory evidence of insurability except if application is made within thirty-one (31) days of birth or within thirty-one (31) days of placement in the home for adoption. Coverage will be issued only when SHL approves this request for change, including the submission of a completed SHL Individual Medical Questionnaire, if applicable. The Effective Date of coverage will be the first day of the month following approval.

SHL 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 Insureds in the same class. In addition, an increase will be applied if an Insured has a birthday which results in an age reclassification on the rate charts. Applicants 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 SHL for a change in coverage now being offered to my Eligible Family Members and me, if any, as shown above. I understand that this application is subject to acceptance by SHL and that if an Agreement is issued, services will be available subject to the terms, exclusions, limitations and benefits described in the Agreement of Coverage and Attachment A, Benefit Schedule.

I hereby certify that I am 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 SHL shall have the right to term coverage retroactively to the original Effective Date and refund any corresponding premium.

Applicant/Guardian Signature: ____**Date:** _____________

Spouse, If Applying:____ **Date:** _____________

Dependent Signature (18 years and over)____________________________________ **Date:** _____________

Dependent Signature (18 years and over)____________________________________ **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.