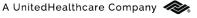
Health Plan of Nevada



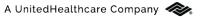
2024 Individual Applicant Enrollment Form



Type of application (check one)		Effective Date: _							
☐ Annual Open Enrollment (11/01/23 – 1/15/24)									
· · · · · · · · · · · · · · · · · · ·	Birth or Adoption	☐ Marriage / Divorce	☐ Permanent Move						
	Loss of Coverage	☐ Other							
Dien selection /places provide all responses in inte									
Plan selection (please provide all responses in ink) Select medi	cal plan by checking th	e box							
MyHPN Solutions HMO Plans		MySHL Solutions EPO & H	ISA Plans						
(Clark/Nye/Washoe County residents only)	D 500#	(Clark County residents only)							
Bronze HMO* Silver HMO*	Bronze EPO*	Silver EPO*							
1 2 1.1 3.1 4 Bronze HMO Plus* Gold HMO*	11 12 Gold EPO*	13 14 1 2 Bronze HSA EPO*	6 7 8 9 Catastrophic EPO*						
3 4 7	7	3.1	(available under age 30)						
Ancillary Products	(Optional) (additional pre	mium applies)							
☐ HPN or SHL Adult Vision Rider, based on plan selection	' (W) _	MO (family coverage for all enr D Adult Dental Plan	ollees)						
STEP Applicant information (please write clearly)									
O2 Coverage type: Myself Myself & Spous	e Myself & Child((ren) Child Only	Family						
Marital status: \square Single \square Married \square Di	vorced	Registered Domestic	Partner (DP)						
First name	Last name		MI						
Physical address (street – not PO Box)	Apt# City, Sta	ite	ZIP						
Mailing/Billing address (if different from above)	Apt# City, Sta	ite	ZIP						
Home phone	Cell phone		•						
Email									
Emergency contact name	Phone								
	_	_							
If this is a Child Only Application – Complete the information below:									
Parent/Legal Guardian as responsible party - print full name Phone									
Agency/Agent information – Must be complete to receive commissions									
Agency/Agent information	- Must be complete to r	receive commissions							
Agency/Agent information - NPN or Commission Entity ID_									
	·	Phone							

*You can also enroll in a health insurance plan for you and your family through the Silver State Health Insurance Exchange (Nevada's state-based health insurance exchange). The Silver State Health Insurance Exchange allows you to get quotes from different insurance companies that are available on the Exchange. You can compare different plans, get quotes and find out if you qualify for financial assistance. The Silver State Health Insurance Exchange is the only way to receive financial assistance for your health insurance. You can enroll online by visiting www.nevadahealthlink.com or by calling 1-800-547-2927, TTY 711.



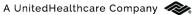


2024 Individual Applicant Enrollment Form



Applicant and Eligible Family Member information										
03	Please list yourself (or child only) and all eligible family members applying for coverage. Only your spouse/domestic partner and/or eligible children (up to age 26) may apply as dependents.									
	This section must be			s and	Depe	ndents		LIDN O. (
	Member information First name Last name			MI		Date of birth	Pri	HPN Option mary Care Provider	ons Only OB/GYN	
Applicant/Child Only							CP) ² or Pediatrician	(for females, age 15+)		
	Social security # (age 5+) Valid Nevada ID # (age 19+) Requ			equire	ired Gender ☐ Male					
ld Only	Medicare A/B eligible ☐ Y ☐ N Tobacco use¹☐ Y ☐ N] N		☐ Female				
Race					Ethnicity (Please choose one option below)			Preferred Spoken and Written Language (Please choose one option below)		
_	ase choose one option below) wo or More Races	·	☐ [Middle Eastern		' '			English		
	American Indian or Alaska Na	tive	☐ White	-		Hispanic/Latino		☐ Non English		
	Asian		☐ Declined		Decli	•		☐ Declined		
	Black or African American Native Hawaiian or Other Paci	fic Islando	☐ Other							
						-			27/21/01	
Sp	First name Last r	name	N	ΜI		Date of birth		imary Care Provider CP) ² or Pediatrician	OB/GYN (for females, age 15+)	
sno	Social security # (age 5+)	Valid Ne		equire	d	Gender	(FCF) OF Fediatrician (1		(lor lemales, age 151)	
e/D.I		Valla 140	vada 12 // (ago 10 ·) 10	oquilo	u	☐ Male				
Spouse/D.Partner	Medicare A/B eligible □ Y □ N Tobacco use¹□ Y □ N] N		□ Female				
Race (Please choose one option below)					Ethnicity (Please choose one option below)			Preferred Spoken and Written Language (Please choose one option below)		
	wo or More Races		☐ [Middle Eastern	וֹ [ר	☐ Hispanic/Latino			☐ English		
	American Indian or Alaska Na	tive	☐ White		☐ Not Hispanic/Latino ☐ Declined			☐ Non English☐ Declined		
	Asian Black or African American		☐ Declined☐ Other							
☐ Native Hawaiian or Other Pacific Islander										
	First name Last	ast name MI		MI				imary Care Provider CP) ² or Pediatrician	OB/GYN (for females, age 15+)	
iid	Social security # (age 5+) Valid Nevada ID # (age 19+) Req			Require	uired Gender □ Male					
1	Medicare A/B eligible ☐ Y ☐ N Tobacco use¹☐ Y ☐ N] N		☐ Female				
Race (Please choose one option below)				Ethnicity (Please choose one option below)			Preferred Spoken and Written Language (Please choose one option below)			
 ☐ Two or More Races ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Image: Middle Eastern ☐ White ☐ Declined ☐ Other 			ן [ר	Hisp	panic/Latino		☐ English			
					Hispanic/Latino		☐ Non English			
				☐ Declined			☐ Declined			
□ Native Hawaiian or Other Pacific Islander										

Health Plan of Nevada



Sierra Health and Life A UnitedHealthcare Company

2024 Individual Applicant Enrollment Form

	First name	Last name		MI Date of birth		Primary Care Provider (PCP) ² or Pediatrician	OB/GYN (for females, age 15+)		
Child 2	Social security # (age 5+)	Valid Ne	Nevada ID # (age 19+) Requi		Gender	(1.0.7.0.1.00.00.00.00.00.00.00.00.00.00.00.00	(ion ioniaios, ago io)		
2	Medicare A/B eligible ☐ Y	□N	Tobacco use¹□ Y □ r	١	☐ Female				
Rac (Ple	e ase choose one option below	<i>(</i>)		Ethnic (Pleas	city se choose one option belo		Preferred Spoken and Written Language (Please choose one option below)		
	☐ Two or More Races ☐ [Middle Eastern] ☐ American Indian or Alaska Native ☐ White ☐ Asian ☐ Declined ☐ Black or African American ☐ Other ☐ Native Hawaiian or Other Pacific Islander			l	spanic/Latino ot Hispanic/Latino eclined	☐ English ☐ Non English ☐ Declined	☐ Non English		
	First name	Last name		MI	Date of birth / /	Primary Care Provider (PCP) ² or Pediatrician	OB/GYN (for females, age 15+)		
Child 3	Social security # (age 5+)	Social security # (age 5+) Valid Nevada ID # (age 19+) Req			Gender ☐ Male ☐ Female				
	Medicare A/B eligible ☐ Y	□N	Tobacco use¹☐ Y ☐ r						
Rac (Ple	e ase choose one option belov	/)		Ethnic (Pleas	city se choose one option belo		Preferred Spoken and Written Language (Please choose one option below)		
□ Two or More Races □ [Middle Eastern] □ American Indian or Alaska Native □ White □ Asian □ Declined □ Black or African American □ Other □ Native Hawaiian or Other Pacific Islander			. □ No	spanic/Latino ot Hispanic/Latino eclined	□ English□ Non English□ Declined				
	First name	Last name		MI	Date of birth / /	Primary Care Provider (PCP) ² or Pediatrician	OB/GYN (for females, age 15+)		
Child	Social security # (age 5+) Valid Nevada ID # (age 19+) Req		quired	Gender ☐ Male					
4	Medicare A/B eligible ☐ Y	□ N Tobacco use¹□ Y □ N		١	☐ Female				
Race (Please choose one option below)				Ethnic (Pleas		Preferred Spoken and Written Language (Please choose one option below)			
Two or More Races ☐ [Middle Eastern] ☐ American Indian or Alaska Native ☐ White ☐ Asian ☐ Declined ☐ Black or African American ☐ Other ☐ Native Hawaiian or Other Pacific Islander			His	spanic/Latino ot Hispanic/Latino eclined	☐ English ☐ Non English ☐ Declined				
Set your delivery preferences (choose one). Opt-in to receive information electronically, request paper documents or update your information. Visit HealthPlanofNevada.com or SierraHealthandLife.com and sign in. First-time users will be directed to create an account using their member ID. (Initial). I am electing to receive all future notices and/or documents from Health Plan of Nevada/Sierra Health and Life in electronic format. (Initial). I am declining to receive all future notices and/or documents from Health Plan of Nevada/Sierra Health and Life in electronic format.									

Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use).

²If enrolling in a Health Plan of Nevada plan, select a Primary Care Provider (PCP) or Pediatrician from the Health Plan of Nevada provider directory available at HealthPlanofNevada.com. Females should also select an OB/GYN physician.

Health Plan of Nevada

A UnitedHealthcare Company

2024 Individual Applicant Enrollment Form



Acknowledgements and application completion - SIGNATURE REQUIRED

By signing this document:

- I, we, or legally Authorized Representative (Brokers, Producer, Agent, etc.) on behalf of client, (hereinafter referred to as Applicant) hereby apply to Health Plan of Nevada/Sierra Health and Life for coverage now being offered to the Eligible persons in this application. Applicant understands that this application for coverage is subject to acceptance by Health Plan of Nevada/Sierra Health and Life and that if an Agreement is issued, service will be available subject to the terms, exclusions, limitations and benefits described in the Health Plan of Nevada/Sierra Health and Life Agreement of Coverage (AOC) and the applicable Attachment A Benefit Schedule and any applicable Endorsements, Riders and Attachments thereto.
- Applicant attests they are not eligible and/or enrolled in Medicare Part A and/or Part B at the time of this application.
- Applicant understands they are entitled to a copy of this form.
- Applicant understands if they are not satisfied for any reason or if the premium rates are not acceptable, within ten (10) days of receiving the AOC, they may return the AOC materials and request a full refund of the premium paid, less any claims paid, if applicable.
- Applicant understands that the payment submitted with this application will be processed at the time of approval and policy issuance.

Applicant represents that all statements and answers in this application are true and complete to the best of their knowledge. Applicant agrees that this shall be the basis of the acceptance of membership. Applicant understands when information provided to Health Plan of Nevada/Sierra Health and Life in this application is determined to be untrue, inaccurate, or incomplete, in lieu of termination of coverage, Health Plan of Nevada/Sierra Health and Life shall have the right to retroactively adjust past premium payments to the maximum rate allowed that would have been billed if such untrue, inaccurate, or incomplete information had properly been provided. If the revised premium rate is not received by Health Plan of Nevada/Sierra Health and Life within thirty (30) days of the letter of notification, coverage will be terminated as of the paid-to-date.

Applicant understands that Nevada requires specific authorization from the applicant agreeing to arbitration. If Applicant is dissatisfied with the findings of an Independent Medical Review, Applicant shall have the right to have the dispute submitted to binding arbitration before an arbitration arbitration Association.

I understand I must provide a physical address for application purposes. Additionally, if I make any intentional misrepresentations of material fact, Health Plan of Nevada/Sierra Health and Life has the right to rescind coverage and declare coverage under the Plan null and void as of the original Effective Date of coverage and refund any applicable premium. An application without a physical address will be returned to me and my requested effective date may be changed as a result.

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes 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.

Internal Individual Sales Rep: Health Plan of Nevada (HPN)/Sierra Health and Life (SHL) pays compensation to licensed professionals contracted and appointed with our company when they sell HPN/SHL Medical products. This compensation is typically a portion of the plan premium and recognizes the licensed professionals services rendered. The plan's premium is the same regardless if a licensed professional is used to apply for and purchase the plan. Per the Consolidated Appropriations Act of 2020, you are being informed of the compensation paid for the sale of this plan, which is up to \$3.33 per month for a 12-month period. The compensation paid may be paid directly to the licensed professional or to a licensed entity with which the licensed professional is employed or affiliated. Additional compensation may be paid later if the licensed professional and/or their agency meets certain criteria in the future and your plan is a part of the calculation of whether such criteria is met. This possibility could effectively result in an increase of the overall compensation earned for the sale of this product but is unknown at this time.

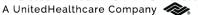
Broker and Internal Individual Sales Rep: Health Plan of Nevada (HPN)/Sierra Health and Life (SHL) pays compensation to licensed professionals contracted and appointed with our company when they sell HPN/SHL Medical products. This compensation is typically a portion of the plan premium and recognizes the licensed professionals services rendered. The plan's premium is the same regardless if a licensed professional is used to apply for and purchase the plan. Per the Consolidated Appropriations Act of 2020, you are being informed of the compensation paid for the sale of this plan, which is up to 3% of premium per month for a 12-month period. The compensation paid may be paid directly to the licensed professional or to a licensed entity with which the licensed professional is employed or affiliated. Additional compensation may be paid later if the licensed professional and/or their agency meets certain criteria in the future and your plan is a part of the calculation of whether such criteria is met. This possibility could effectively result in an increase of the overall compensation earned for the sale of this product but is unknown at this time.

the overall compensal	tion carried for the sale of this product but is driknown at this time.
Signature	Date
I acknowledge that t	he information provided in this application is true and that:
Initials Initials Initials	I am a resident of Nevada and reside in the service area of which I have applied for coverage I may be required to provide proof of residency. I attest that no non-licensed third party (e.g., medical facility) assisted me in the completion of this application.
understands and here Authorized Represent request.	ESENTATIVE. If an Authorized Representative is completing this application on behalf of a client, the Authorized Representative by attests that they have written authorization from his/her client to apply for health insurance coverage on behalf of his/her client. The ative further attests that such written documentation will be made available to Health Plan of Nevada/Sierra Health and Life upon JRT APPOINTED LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ON BEHALF OF APPLICANT:
APPLICANT OR COL	JRT APPOINTED LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ON BEHALF OF APPLICANT:

Date

Signature





2024 Individual Applicant Enrollment Form



Premium payment options PLEA In order to enroll through Health Plan of Nevada/Sierra Health application submission.	SE PRINT CLEA and Life, you ar		e an initial premiu	ım payment at the	time of			
Applicant/Member First name	Last	name			MI			
Applicant/Member email address		Phon	е –	_				
Is a third party providing funds to pay the premiums for your insurance coverage? If yes, please identify the third party providing funds (directly/indirectly) to pay the premiums: The following are the only acceptable third parties who may pay HPN/SHL premiums on the Member/Insured's behalf: Ryan White HIV/AIDS program under the Title XXVI of the Public Health Service Act; Indian tribes, tribal organizations, or urban Indian organizations; Employer; State and Federal government programs; or Family members. I will pay with the following payment option: I will pay with the following payment option:								
Credit/Debit card Check or money order If choosing to pay by credit/debit card, you must complete all of the following information: Cardholder name as it appears on card								
Cardholder billing address City			State	ZIP				
Credit card #		Exp date (M	IM/YY)/_					
Checking Favor Four pay by FFT/ACH Dank draft, you must complete all of the following information: Bank account holder name as it appears on bank statement Account holder address Type of account Checking Savings Routing #								
Amount to charge upon application submission \$ Initial and Recurring Monthly Payments Lauthorize Heal bank account for the payment amount shown above at the Health and Life to charge my credit/debit card OR debit my this Individual Plan from Health Plan of Nevada/Sierra Heal Initial Payment Only Lauthorize Health Plan of Nevada/S payment amount shown above at the time my Application approval of this Application and may or may not be my final credits will be applied to future billings. Recurring Monthly Payments Lauthorize Health Plan of account to the monthly billed premium and/or any past due The monthly premium will be automatically charged to the credit above (or next business day if a weekend or holiday) for which Health of Nevada/Sierra Health and Life have received written.	e time my Applica y bank account e alth and Life. Sierra Health and is submitted. I ur al monthly premion Nevada/Sierra He premiums for the it/debit card or do the premium is co	(Date will be the da/Sierra Health attion is submitted. equal to the month.) Life to charge mynderstand the amoum. I am response Health and Life to do is Individual Planebited from the ballue. This authorize of its termination.	and Life to charge I also authorize H ly billed premium credit/debit OR dount authorized with the charge my credit/of from Health Plannk account indicatation is to remain in such a manne	e month if no date my credit/debit car lealth Plan of Neva and/or any past du lebit my bank acco ll be charged in its nium due on my a debit card OR debi of Nevada/Sierra I ted above on the d in in full force and or as to afford Healt	d OR debit my da/Sierra le premiums for unt for the entirety upon ccount. Any the my bank dealth and Life, ate specified defect until the Plan of			
Nevada/Sierra Health and Life and the financial institution a real increased premium rate will be deducted from your account account.	asonable opportu	nity to act on it. In	the event your r	monthly premium	s increase, the			
Card/Account holder signature			Date					