

HEALTH PLAN OF NEVADA A UnitedHealthcare Company



UnitedHealthcare

A UnitedHealth Group Company

Selectable Option Enrollment Form

Instructions

Shaded areas at the top of the form are to be completed by your Employer prior to final submission and approval.

Section A: Employee Information

Please complete information requested.

Section B: Eligible Family Member(s) Information

- List Eligible Family Member(s) who are enrolling. You may attach an additional sheet if necessary.
- If declining any medical coverage offered you, your spouse, or your Eligible Family Member(s), you must complete Section E Waiver of Coverage.

HPN Plans Only:

- Primary Care Physician (PCP) selection is not required for HPN Open Access or SHL Plans.
- 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.

Section C: Coverage Selection

- Please check all boxes that apply.
- Benefit plans offered are dependent upon your Employer's selection.
- Complete the Life Insurance Beneficiary's information requested if your Employer offers this benefit.

Section D: Other Medical Coverage Information

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

Section E: Waiver of Coverage Section E **must** be completed and signed if you are declining any Employer offered coverage for you, your spouse, or your Eligible Family Member(s).

Section F: Signature

A UnitedHealthcare Company

- 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.

Terms and Conditions – Please read carefully before signing

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.

HPN Medical Temporary Enrollment ID Card	SHL Medical Temporary Enrollment ID Card	Complete the attached temporary Enrollment ID Cards and keep until you receive your
Name:	Name:	permanent ID Card.
Effective Date:	Effective Date:	HPN Member Services
Employer Name:	Employer Name:	(702) 242-7300 or 1-800-777-1840
Group Number:	Group Number:	SHL Member Services
Coverage shall not begin until acceptance of enrollment.	your Coverage shall not begin until acceptance of yo enrollment.	ur (702) 242-7700 or 1-800-888-2264

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).

UnitedHealthc	are and Affiliates
Medical Cover	rage provided by:
Health Plan of Nevada, a UnitedHealthcare Company P.O. Box 15645 Las Vegas, NV 89114-5645 Member Services: (702) 242-7300 or 1-800-777-1840	Sierra Health and Life, a UnitedHealthcare Company P.O. Box 15645 Las Vegas, NV 89114-5645 Member Services: (702) 242-7700 or 1-800-888-2264
Dental Covera	age provided by:
Sierra Health and Life Member Services: (702) 242-7700 or 1-800-888-2264	United Healthcare Insurance Company 450 Columbus Boulevard Hartford, CT 06115-0450 Contact Number: 1-877-816-3596
Life Insurance	Coverage provided by:
Sierra Health and Life Member Services: (702) 242-7700 or 1-800-888-2264	United Healthcare Insurance Company Contact Number: 1-866-615-8727
Vision Covera	age provided by:
Health Plan of Nevada Member Services: (702) 242-7300 or 1-800-777-1840	United Healthcare Insurance Company Contact Number: 1-800-638-3120
Sierra Health and Life Member Services: (702) 242-7700 or 1-800-888-2264	

Employee: To receive your ID card, please CLEARLY complete all non-shaded areas and sign Section F.					Employer Verification Signature and Date:								
Shaded Are		This Form To Be Compl	eted by Employ	ver		Group/Subgroup Number:							
Date of Hire	¹ (mm/dd/yy)	: / /								ip Name:			
Position/Title		· · ·		Deccep for					or Date of		/	/	μ.λ.
				Reason for D Open Eni	Application	□ ive □ Sta	w Hire ⊐ atus Chano	Renire ⊑ ie	New Grou			ype (check all that app Hourly □ Salary	
Dept. Code:		Class Code:		D Change N								Non-Union \square Retired	
Annual Salary(for Life Ins.): \$ Other									COBRA or State Continuation				
Employee # (if applicable):Termination D Voluntar										Start Date/ End date//			
	e Information												
Last Name			First Name			MI	Soc	al Security	Number			lome Phone ()	
Address			Apt #	City			Stat	<u> -</u>	Zip Code			ell Phone ()	
71001035			npt #	Ony			Sidi	0			L		
Date of Birth			Sex □M	Date of Hire ¹			HPN	I Primary (Care Provide	er Code ³	Н	IPN OB/GYN Provider	Code ³
(mm/dd/yy)	0		F	(mm/dd/yy)					-				
		□ Married □ Divorced k? □ Yes □ No If Ye	Widowed es, how often?				Hav	e you prev	iously been	a Member of H	IPN or S	SHL? □ Yes □ No	
		er(s) Information ⁴ (Com		pendent covera	ae is desired	Attac	h additio	nal sheet.	if necessar	rv)			
		p is different than the option					Sex	1) Birth	date (mm/o al Security #	dd/yy) Full-ti		HPN Primary Care Provider Code ³	HPN OB/GYN Provider Code ³
Spouse	Last Name		First Nan	ne		MI		F 1) 2)					
Child	Last Name		First Nan	ne		MI		= 1) 2)		🗆 Yes 🛛	⊐ No		
Child	Last Name		First Nan	ne		MI		= 1)		🗆 Yes 🛛	⊐ No		
Child	Last Name		First Nan	ne		MI		= <u>1)</u> 2)		Yes [⊐ No		
C. Eligible E	mployee Cov	verage Selection: Pleas	e check one bo	ox for coverage	under each p	oroduct	offered b	y Émploy	er. If box is	s not selected	, cover	age is considered wa	ived.
Covered Me	embers	HMO Medical-Rx	POS M	edical-Rx	PPO N	/ledica	I-Rx	De	ental	Vision	Ba	asic Life & AD&D	Dependent Life
Employee													
		Coverage Selection: P ox is not selected, cove			age under eac	ch prod	luct offere	ed by Emp	loyer. Elig	ible Family Me	embers	can only select a pro	oduct if the Employee
Spouse													
Eligible Fam	ily Members												
Plan/Benefit	Selection										\$		\$
Life Insurance Beneficiary's Full Name and Address					<u> </u>			1				ationship to the Employ	lee
¹ If the emplo Enter the nu required. Fe	oyee is reclas. Imber found ne males may ch	sified to full-time status, p ext to the Provider you ch pose one medical <u>care P</u>	lease provide th oose as a PCP. CP and one OB/	e date of full-time PCP Selection: 'GYN. 4 If declir	e employment. HPN HMO & P ning any medic	²Leg POS Pla cal cove	al docume ans = requ erage offei	ntation mu iired; HPN ed you or	ist be attach Open Acce /our Eligible	hed. ³ Refer to ss Plans = not e Family Membe	the HF require ers, you	PN Primary Care Provid d, but recommended; s nust complete Sectio	der (PCP) Directory. SHL Plans = not n E Waiver of Coverage.

Employee Name: _____

SSN: _____

Relationsh	nip			Sex	Birthdate	Full-time Student	HPN (only) Primary Care Provider Code	HPN (only) OB/GYN Provider Code
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.		I					
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.		I					
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.		I					
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							

Relationsh	lip			Sex	Birthdate	Full-time Student	HPN (only) Primary Care Provider Code	HPN (only) OB/GYN Provider Code
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.		I					
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F				
	Social Security No.				□ No			
Child	Last Name	First Name	MI			□ Yes		
	Social Security No.	🗆 F		□ No				
Child	Last Name	First Name	MI	□ M □ F				
	Social Security No.					□ No		
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	M		□ Yes □ No		
	Social Security No.							
Child	Last Name	First Name	MI	□ M □ F				
	Social Security No.		I			□ No		

	nation (This Section D must be c	ompleted Att	ach sheet if necessary)					
On the day this coverage begins wi					in or policy, including another HPN and UHC a	and Affiliates plan or Medicare?			
\Box YES (continue completing this Se				medical nearth pia	in or policy, including another the work of the	and Anniales plan of Medicare?			
Other Group Medical Coverage Info		Туре	Effective Date	End Date	Name and date of birth of policyholder for o	other coverage			
(only list those covered by other pla		(A, B or S)*	Lincourto Dato						
Spouse Name:									
dependent Name:									
dependent Name:									
dependent Name:									
* A. Enter "A" if this dependent is co	vered by Another individual (not a	member of you	r household) required to	pay for this depend	dent's medical expenses.				
B. Enter "B" if this dependent is co									
S. Enter "S" if you are the Sole par			her individual is required	to pay for this depe	endent's medical expenses.				
Medicare-Employee Information: If			Medicare ID Card. Me	dicare – Spouse/de	ependent Name:				
□ Enrolled in Part A: Effective Date	□ Ineligible for Part A	☐ I chose not to	o enroll in "Part A".	Enrolled in Part A: I	Effective Date Ineligible for Part A	$A \square$ Chose not to enroll in "Part A".			
□ Enrolled in Part B: Effective Date	□ Ineligible for Part B	I chose not to	o enroll in "Part B".	Enrolled in Part B: I	Effective Date Ineligible for Part E	B \square Chose not to enroll in "Part B".			
Reason for Medicare eligibility:	ver 65 🗆 Kidney Disease 🗆 Dis	abled	Re	ason for Medicare	eligibility: 🗆 Over 65 🛛 Kidney Disease 🗆				
E. Waiver of Coverage (This Section			ng medical coverage)						
I decline coverage for:	I am declining coverage due to ot	her existing me	edical coverage. (Please	e provide a 🛛 I und	derstand that by waiving coverage at this time,	, I will not be allowed to participate			
□ Myself	copy of your other existing medic				ss I experience a Special Enrollment Event or	at the next Open Enrollment			
Spouse	Spouse's Employer's Plan	🗆 Individu	al Plan 🛛 Other	Perie	od. I also understand that Preexisting Condition	on Limitations may apply.			
dependent Children	Medicare	Medicai	d	Emr	ployee Signature	Date			
Myself and all Eligible Family	COBRA from Prior Employer	🗆 🛛 VA Eligi		-	Joyee Signature	Dale			
Members	□ Tri-Care	🗆 I (we) ha	ave no other coverage at	this time					
F. Signature (Form must be signed	ed)								
I authorize HPN, SHL and/or UHC a	and Affiliatos to obtain uso and disc								
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									
these records may contain informati	on created by other persons or ent	ities (including	health care providers) a	s well as informatio	n regarding the use of drug, alcohol, HIV/AIDS	S, mental health (other than			
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