HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

2025 Individual Application

Effective Date: _____

Type of application (check one)

☐ Annual Open Enrollment (11/01/24 – 1/15/25)
☐ Qualifying Life Event Type of Event: ☐ Birth or Adoption ☐ Marriage / Divorce ☐ Permanent Move ☐ Loss of Coverage ☐ Other_____
Date of Event____/____/_____

*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**.

STEP 01 Did an agent or broker help you? If so, make sure they complete this portion

NPN or Commission Entity ID_____ Phone _____
Agency name_____ Agent name_____

STEP 02 Plan selection (please provide all responses in ink)

Select medical plan by checking the box

MyHPN Solutions HMO Plans (Clark/Nye/Washoe County residents only)					MySHL Solutions EPO & HSA Plans (Clark County residents only)									
Bronze HMO*		Silver HMO*			Bronze EPO*				Silver EPO*					
☐ 1	☐ 2	☐ 1.1	☐ 3.1	☐ 4	☐ 11	☐ 12	☐ 13	☐ 14	☐ 1	☐ 2	☐ 6	☐ 7	☐ 8	☐ 9
Bronze HMO Plus*		Gold HMO*			Gold EPO*		Bronze HSA EPO*		Catastrophic EPO* (available under age 30)					
☐ 3	☐ 4	☐ 7			☐ 7		☐ 3.1		☐					

Optional Ancillary Products (additional premium applies)
(must select a medical plan above to purchase dental and/or vision)

☐ HPN or SHL Adult Vision Rider, based on plan selection

☐ DHMO (family coverage for all enrollees)
☐ PPO Adult Dental Plan

STEP 03 Applicant information (please write clearly)

Coverage type: ☐ Myself ☐ Myself & Spouse ☐ Myself & Child(ren) ☐ Child Only ☐ Family

If this is a Child Only Application – Complete the information below:
Parent/Legal Guardian as responsible party - print full name | Phone

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner (DP)

First name	Last name	MI	Date of birth

Social security # (age 5+)	Valid Nevada ID # (age 19+) Required	Gender	Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females, if applicable)
		☐ Male ☐ Female		
Medicare A/B ☐ Y ☐ N (Not eligible if enrolled)	Tobacco use[1] ☐ Y ☐ N			

Physical address (street – **not** PO Box)	Apt#	City, State	ZIP
Mailing/Billing address (if different from above)	Apt#	City, State	ZIP

Home phone	Cell phone

Step 3 continued

Email	
Emergency contact name	Phone

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	☐ Middle Eastern	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ White	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Native Hawaiian or Other Pacific Islander			

ICHRA (Individual Coverage Health Reimbursement Arrangement): ☐ Yes ☐ No ☐ Unknown

QSEHRA (Qualified Small Employer Health Reimbursement Arrangement): ☐ Yes ☐ No ☐ Unknown

If Yes, check applicable boxes

QSEHRA Plan Premium
- ☐ Subscriber QSEHRA used for Plan Premium
- ☐ Spousal QSEHRA used For Plan Premium
- ☐ Not Applicable ☐ Unknown

QSEHRA Medical/Rx Claims
- ☐ Subscriber QSEHRA used for medical and/or Rx claim reimbursement
- ☐ Spousal QSEHRA used for medical and/or Rx claim reimbursement
- ☐ Subscriber and Spousal QSEHRA used for medical and/or Rx claim reimbursement
- ☐ Not Applicable ☐ Unknown

STEP 04 **Eligible Family Member information**

Please list all eligible family members applying for coverage. Only your spouse/domestic partner and/or eligible children (up to age 26) may apply as dependents.

Spouse/D.Partner

First name	Last name	MI	Date of birth

Social security # (age 5+)	Valid Nevada ID # (age 19+) Required	Gender	Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females, if applicable)
		☐ Male ☐ Female		

Medicare A/B ☐ Y ☐ N (Not eligible if enrolled)

Tobacco use[1] ☐ Y ☐ N

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	☐ Middle Eastern	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ White	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Native Hawaiian or Other Pacific Islander			

Child 1

First name	Last name	MI	Date of birth

Social security # (age 5+) - -	Valid Nevada ID # (age 19+) Required	Gender	Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females, if applicable)
		☐ Male ☐ Female		

Medicare A/B ☐ Y ☐ N (Not eligible if enrolled)

Tobacco use[1] ☐ Y ☐ N

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	☐ Middle Eastern	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ White	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Native Hawaiian or Other Pacific Islander			

Step 4 continued

Child 2

First name	Last name	MI	Date of birth

Social security # (age 5+)	Valid Nevada ID # (age 19+) Required	Gender	Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females, if applicable)
		☐ Male ☐ Female		
Medicare A/B ☐ Y ☐ N (Not eligible if enrolled)	Tobacco use[1] ☐ Y ☐ N			

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	☐ Middle Eastern	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ White	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Native Hawaiian or Other Pacific Islander			

Child 3

First name	Last name	MI	Date of birth

Social security # (age 5+)	Valid Nevada ID # (age 19+) Required	Gender	Primary Care Provider (PCP)[2] or Pediatrician	OB/GYN (for females, if applicable)
		☐ Male ☐ Female		
Medicare A/B ☐ Y ☐ N (Not eligible if enrolled)	Tobacco use[1] ☐ Y ☐ N			

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	☐ Middle Eastern	☐ Hispanic/Latino	☐ English
☐ American Indian or Alaska Native	☐ White	☐ Not Hispanic/Latino	☐ Non English
☐ Asian	☐ Declined	☐ Declined	☐ Declined
☐ Black or African American	☐ Other		
☐ Native Hawaiian or Other Pacific Islander			

Email Address for paperless communications: _____

By providing your email address, you agree, 1) to be automatically enrolled in paperless delivery for some of your plan communications, and 2) you have reviewed the Required Plan Communications Notice[3]. You also agree to receive Required Plan Communications electronically.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (such as: benefit and plan information, claims, billing and payments, regulatory notices and tax documents) are available online.

If you would rather have hard copies of required materials mailed to you, please check here:

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time by signing in to the online member center.

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

[2]If 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.

[3]Certain laws require that we give specific information to you in writing. We may send Required Plan Communications electronically when you give us permission. Not all Communications require permission before sending. This Notice only applies when permission is required. You may change your mind at any time, and we will send paper communications to you. These Communications may include: Plan documents and legal notices; Benefit decisions, such as Explanation of Benefits; and Privacy notices. Communications are based on the Plan you have. You will get new communications as they become electronic. If there is not an electronic version, we will send by mail.

How will Communications be sent? We will send you an email when a document is ready to view online.

What if my email changes? Update your email right away. It is your responsibility to give us correct information. Communications may be delayed if we have the wrong information. If this happens, you hold us harmless.

What happens if I change plans? If you change or add a benefit plan, program, product or service, we may use the same contact information you provided before.

Can I go back to mail? Yes, you may change your mind at any time. You may change your choice by going to your member website or mobile application or call the member number on your ID card. Paperless delivery will stay until you change your choice to mail. Changes may take up to seven business days to process.

Can I get a paper copy? Yes, you have the right to a free paper copy. You may print a copy on your member website or call the member number on your ID card and we will mail it to you.

Hardware and software requirements In order to get, view, and keep these Communications you must have, at your own cost, the following: Internet or Mobile access; Registration on member website; An email account with software; and Acrobat Reader or similar software to view PDF files.

[a]We means United HealthCare Services, Inc. and/or Optum, Inc. and/or their affiliated companies

STEP 05

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 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 arbiter under the commercial arbitration rules applied by the American 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.

Signature_____ Date_____

I acknowledge that the information provided in this application is true and that:

Initials_____ **I am a resident of Nevada and reside in the service area of which I have applied for coverage**

Initials_____ **I may be required to provide proof of residency.**

Initials_____ **I attest that no non-licensed third party (e.g., medical facility) assisted me in the completion of this application.**

AUTHORIZED REPRESENTATIVE. If an Authorized Representative is completing this application on behalf of a client, the Authorized Representative understands and hereby attests that they have written authorization from his/her client to apply for health insurance coverage on behalf of his/her client. The Authorized Representative further attests that such written documentation will be made available to Health Plan of Nevada/Sierra Health and Life upon request.

APPLICANT OR COURT APPOINTED LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ON BEHALF OF APPLICANT:

Signature_____ Date_____

Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life®
A UnitedHealthcare Company

2025 Individual Payment Selection Form

PLEASE PRINT CLEARLY

Applicant/Member First name	Last name	MI

Premium payment options

You are required to make an initial premium payment at the time of application.

Is a third party providing funds to pay the premiums for your insurance coverage? ☐ Yes ☐ No

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.

If payment from the Member/Insured is received and premium is determined to be from a non-acceptable third party, the Member/Insured will be informed that the payment will be returned and that the premium payment remains due by an acceptable party. If the premium payment is not received from an acceptable party within the premium grace period the policy will be terminated for nonpayment of premium.

I will pay with the following payment option:

☐ Credit/Debit card ☐ EFT/ACH bank draft ☐ 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 (MM/YY) _____/_____	CVV/CVC	
Email address	Cell phone		

– – – OR – – –

If choosing to pay by **EFT/ACH bank 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 #	Bank account #	
Email address	Cell phone	

Amount to charge upon application submission $_____

Select day of month for recurring payments _____
(Date will be the 10th day of the month if no date is entered)

☐ ***Initial and Recurring Monthly Payments*** I authorize Health Plan of Nevada/Sierra Health and Life to charge my credit/debit card OR debit my bank account for the payment amount shown above at the time my Application is submitted. I also authorize Health Plan of Nevada/Sierra Health and Life to charge my credit/debit card OR debit my bank account equal to the monthly billed premium and/or any past due premiums for this Individual Plan from Health Plan of Nevada/Sierra Health and Life.

☐ ***Initial Payment Only*** I authorize Health Plan of Nevada/Sierra Health and Life to charge my credit/debit OR debit my bank account for the payment amount shown above at the time my Application is submitted. I understand the amount authorized will be charged in its entirety upon approval of this Application and may or may not be my final monthly premium. **I am responsible for any premium due on my account. Any credits will be applied to future billings.**

☐ ***Recurring Monthly Payments*** I authorize Health Plan of Nevada/Sierra Health and Life to charge my credit/debit card OR debit my bank account to the monthly billed premium and/or any past due premiums for this Individual Plan from Health Plan of Nevada/Sierra Health and Life.

The monthly premium will be automatically charged to the credit/debit card or debited from the bank account indicated above on the date specified above (or next business day if a weekend or holiday) for which the premium is due. **This authorization is to remain in full force and effect until Health of Nevada/Sierra Health and Life have received written notification of its termination** in such a manner as to afford Health Plan of Nevada/Sierra Health and Life and the financial institution a reasonable opportunity to act on it. **In the event your monthly premiums increase, the increased premium rate will be deducted from your account.** Member can change and/or terminate monthly payments by logging on to their account.

Card/Account holder signature_____ Date_____