



*health insurance • life insurance • disability insurance • retirement planning*

Enclosed is the **Health Plan of Nevada** application you requested. To avoid unnecessary delays in the underwriting process, please be sure to complete the application in full and attach your first months premium. The following tips may help you:

1. Read and Sign the enclosed "Health Insurance Application Disclosure Statement/Acknowledgement". This document must be included with your application to ensure prompt processing.
2. Individual Enrollment Application, complete all information. The oldest person applying must be the applicant. Don't forget to mark the deductible plan that you have chosen. On the back, chose your effective date, sign and date where indicated.
3. Please fill out the Medical Questionnaire completely. Include your verification phone number. Sign where indicated on the back page.
4. Complete and include the applicant authorization form.
5. Complete the dependant child form for any child under 17.
6. Submit your **first month's premium** by check or money order **made payable to "Health Plan of Nevada"**. If we do not have the first months premium, we can not process your application. This is very important!
7. Health Plan of Nevada's medical underwriting department will contact you for a telephone interview as part of the enrollment process.

**Billing Options:**

- If you choose to have your monthly premium debited directly from your checking account, thereby saving the \$10 direct billing charge, complete the **Authorization Agreement for Pre-arranged Payment Form**. Please sign where indicated at the bottom and provide a **voided check**.
- If you choose to have your premium billed, please include an additional **\$10 check** with your application. The check needs to be **made payable to "Health Plan of Nevada"**. The \$10 fee will continue to be applied monthly to your billings.

Rates quoted are based on good health status. Rates have possibility of increasing by up to 75%.

The deadline for a 1<sup>st</sup> of the month effective date is noon of the business day before the 20<sup>th</sup> of the previous month. The deadline for a 15<sup>th</sup> of the month effective date is noon of the business day before the 5<sup>th</sup> of the month.

Please mail the entire application along with the premium check (and \$10 or voided check) to our office address as listed below, or deliver to our office to meet the deadline. If you have any questions, please give us a call at **(775) 329-1995**.

Thank You

**Health Plan of Nevada - No. NV  
Distinct Advantage HMO Plans  
Effective 11/1/09**

**Distinct Advantage HMO Option 1  
with Prescription Benefit Rider \$10/35/60 Rx  
Includes 12 month Maternity Waiting Period  
(SurePay Billing Option\* for automatic bank withdrawal)**

Age	Male Subscriber	Female Subscriber	Subscriber & Spouse	Male Subscriber & Children	Female Subscriber & Children	Family
0 - 17	171.00	171.00				
18 - 24	140.00	339.00	479.00	437.00	637.00	811.00
25 - 29	155.00	371.00	527.00	452.00	669.00	856.00
30 - 34	171.00	387.00	557.00	468.00	684.00	884.00
35 - 39	186.00	385.00	569.00	482.00	682.00	897.00
40 - 44	263.00	418.00	681.00	561.00	715.00	994.00
45 - 49	277.00	448.00	725.00	575.00	745.00	1,035.00
50 - 54	434.00	527.00	960.00	729.00	823.00	1,245.00
55 - 59	586.00	679.00	1,268.00	885.00	977.00	1,524.00
60 - 64	737.00	737.00	1,472.00	1,034.00	1,034.00	1,708.00
65+	990.00	1,051.00	2,041.00	1,287.00	1,349.00	2,218.00

**NOTE: For "Subscriber & Spouse" and "Family" policies, the OLDER spouse must be the applicant.**

**Distinct Advantage HMO Option 2  
with Prescription Benefit Rider \$10/35/60 Rx  
Does Not Include Maternity Coverage  
(SurePay Billing Option\* for automatic bank withdrawal)**

Age	Male Subscriber	Female Subscriber	Subscriber & Spouse	Male Subscriber & Children	Female Subscriber & Children	Family
0 - 17	134.00	134.00				
18 - 24	107.00	243.00	350.00	339.00	476.00	614.00
25 - 29	122.00	256.00	376.00	354.00	488.00	638.00
30 - 34	134.00	278.00	412.00	367.00	511.00	671.00
35 - 39	146.00	291.00	437.00	377.00	522.00	691.00
40 - 44	204.00	302.00	505.00	437.00	533.00	754.00
45 - 49	218.00	350.00	568.00	452.00	583.00	811.00
50 - 54	337.00	413.00	752.00	569.00	646.00	977.00
55 - 59	461.00	530.00	990.00	692.00	761.00	1,191.00
60 - 64	570.00	576.00	1,146.00	806.00	808.00	1,334.00
65+	773.00	821.00	1,592.00	1,005.00	1,052.00	1,733.00

**NOTE: For "Subscriber & Spouse" and "Family" policies, the OLDER spouse must be the applicant.**

**\*DIRECT BILL OPTION (to receive monthly bill by mail):** To calculate rates for having the bill sent to your home, add \$10.00 to the above medical rates. Health Plan of Nevada, Inc. has the right to increase premiums for the agreement after providing 60 days notice to the Applicant/Subscriber. In addition, an increase **will** be applied if an Applicant/Subscriber has a birthday which results in an age reclassification of the rate charts.

**Notice: These rates are for non-smoker preferred individuals. Rates may increase up to 75% based on the medical history of the applicants. New enrollees are subject to medical underwriting.**

**Health Plan of Nevada - No. NV  
Distinct Advantage HMO Plans  
Effective 11/1/09**

**Distinct Advantage POS Option 3  
with Prescription Benefit Rider \$10/35/60 Rx  
Includes 12 month Maternity Waiting Period  
(SurePay Billing Option\* for automatic bank withdrawal)**

Age	Male Subscriber	Female Subscriber	Subscriber & Spouse	Male Subscriber & Children	Female Subscriber & Children	Family
0 - 17	195.00	195.00				
18 - 24	157.00	387.00	543.00	496.00	726.00	926.00
25 - 29	177.00	420.00	598.00	517.00	759.00	973.00
30 - 34	195.00	437.00	631.00	534.00	777.00	1,006.00
35 - 39	208.00	437.00	647.00	549.00	777.00	1,018.00
40 - 44	296.00	474.00	770.00	636.00	814.00	1,129.00
45 - 49	313.00	507.00	820.00	652.00	845.00	1,175.00
50 - 54	491.00	592.00	1,084.00	831.00	932.00	1,415.00
55 - 59	665.00	769.00	1,433.00	1,006.00	1,109.00	1,726.00
60 - 64	832.00	831.00	1,663.00	1,172.00	1,168.00	1,934.00
65+	1,118.00	1,188.00	2,307.00	1,457.00	1,529.00	2,515.00

**NOTE: For "Subscriber & Spouse" and "Family" policies, the OLDER spouse must be the applicant.**

**Distinct Advantage HMO Option 4  
with Prescription Benefit Rider \$10/35/60 Rx  
Does Not Include Maternity Coverage  
(SurePay Billing Option\* for automatic bank withdrawal)**

Age	Male Subscriber	Female Subscriber	Subscriber & Spouse	Male Subscriber & Children	Female Subscriber & Children	Family
0 - 17	128.00	128.00				
18 - 24	104.00	235.00	339.00	330.00	461.00	596.00
25 - 29	118.00	246.00	366.00	342.00	472.00	615.00
30 - 34	128.00	268.00	397.00	354.00	493.00	646.00
35 - 39	141.00	279.00	422.00	367.00	505.00	669.00
40 - 44	197.00	292.00	489.00	423.00	517.00	729.00
45 - 49	211.00	339.00	550.00	437.00	565.00	785.00
50 - 54	327.00	399.00	725.00	552.00	623.00	944.00
55 - 59	446.00	511.00	956.00	671.00	737.00	1,150.00
60 - 64	553.00	557.00	1,111.00	779.00	781.00	1,288.00
65+	746.00	793.00	1,540.00	971.00	1,018.00	1,673.00

**NOTE: For "Subscriber & Spouse" and "Family" policies, the OLDER spouse must be the applicant.**

**\*DIRECT BILL OPTION (to receive monthly bill by mail):** To calculate rates for having the bill sent to your home, add \$10.00 to the above medical rates. Health Plan of Nevada, Inc. has the right to increase premiums for the agreement after providing 60 days notice to the Applicant/Subscriber. In addition, an increase will be applied if an Applicant/Subscriber has a birthday which results in an age reclassification of the rate charts.

**Notice: These rates are for non-smoker preferred individuals. Rates may increase up to 75% based on the medical history of the applicants. New enrollees are subject to medical underwriting.**

Area for HPN use only:  
 Declined Date Processed: \_\_\_/\_\_\_/\_\_\_  
 Accepted Effective Date: \_\_\_/\_\_\_/\_\_\_  
 Underwriter

### Individual HMO Enrollment Application Form

Please mark your selection.  
 Option 1 (HMO) \*12-month MWP  
 Option 2 (HMO) \*No Maternity Coverage  
 Option 3 (POS) \*12-month MWP  
 Option 4 (HMO) \*No Maternity Coverage  
 Direct Bill  
 Sure Pay (AutoPay)

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Date of Marriage: \_\_\_\_\_  
 Applicant Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Street Apt # City State/Zip County  
 Billing Address: (If different than above) \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Business Phone: (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Employer Name/Address: \_\_\_\_\_ Street Apt # City State/Zip  
 Emergency Contact Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**Dental:**  
 Yes \_\_\_ No \_\_\_  
 Coverage applies to Southern Nevada only

**I qualify for a HIPAA Plan:**  
 Standard \_\_\_ Basic \_\_\_  
 I have attached proof that I meet the following HIPAA eligibility requirements:  
 1. My HIPAA qualifying event occurred no more than sixty-three (63) days prior to the date of this application;  
 2. Most recent healthcare coverage was under a Group Plan;  
 3. Have a minimum aggregate period of eighteen (18) months of Creditable Coverage;  
 4. Exhausted COBRA or similar continuation of coverage, if applicable;  
 5. Not covered by other healthcare coverage;  
 6. Do not qualify for Medicare or Medicaid;  
 7. Did not have Group healthcare coverage terminated for fraud or non-payment of premiums.

**Vision (optional):**  
 Yes \_\_\_ No \_\_\_

**PLEASE LIST YOURSELF AND ALL ELIGIBLE FAMILY MEMBERS APPLYING FOR COVERAGE.** Only your spouse and Eligible Family Member(s) under the age of 24 may apply except that those children between the ages of 19 and 24 are not eligible as Dependents unless they are full-time students and unmarried. If your child does not qualify as an Eligible Family Member, he/she may apply for his/her own Individual healthcare coverage.

**THIS SECTION MUST BE COMPLETED**

Last Name	First Name	MI	Sex M or F	Relationship to Applicant	Birthdate	SS#	HPN Primary Care Physician*	HPN OB/GYN (For Females)*	ESD#
				Applicant					

**\* SELECT A PHYSICIAN CODE FROM THE HPN PROVIDER DIRECTORY INCLUDED IN YOUR ENROLLMENT PACKAGE. FEMALES SHOULD ALSO SELECT AN OB/GYN PHYSICIAN.**



## INDIVIDUAL MEDICAL QUESTIONNAIRE

Please type or print in **BLACK INK** – An Individual Medical Questionnaire must be completed for each applicant.  
**ALL QUESTIONS MUST BE ANSWERED**

Completion of the Individual Medical Questionnaire is required for: (1) Coverage on self; (2) Coverage on spouse; (3) Coverage on any eligible dependent child if application is made more than thirty-one (31) days after acquiring child; (4) Coverage which was previously waived, declined, terminated on an Eligible Family Member; and (5) Any increase in benefits.

**NOTE:** A family applying together does not guarantee that all family members will be accepted for coverage. If only a portion of your family is accepted, you will be contacted by HPN for further instructions regarding your application for coverage.

Applicant Information									
Applicant Number	Last	Name First	MI	Sex	Date of Birth mo/day/yr	Height	Weight	Birthplace City State	Current Physician Name Address
Self				<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					

### PART I PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Do you currently have, or has anyone applying for coverage had prior healthcare coverage in the past twelve (12) months?  
 Yes  No

If yes, name of Member/Insured: \_\_\_\_\_  
 Name of HMO/Insurance Carrier: \_\_\_\_\_

a) Was coverage provided by an:  HMO  Group Policy  Individual Policy  
 b) Effective Date: \_\_\_/\_\_\_/\_\_\_ c) Termination Date: \_\_\_/\_\_\_/\_\_\_ Reason for Termination: \_\_\_\_\_

If the termination date of prior healthcare coverage is within sixty-three (63) days of the date the Individual Medical Questionnaire is signed, please attach the Certificate of Creditable Coverage. **(This is mandatory for persons applying for the HIPAA Standard or Basic Plans.)**

d) If this application is accepted, do you agree to discontinue your current coverage?  Yes  No  
 e) Are you or any Eligible Family Member currently enrolled on COBRA?  Yes  No  
 If yes, Termination Date: \_\_\_/\_\_\_/\_\_\_

2. Is either the applicant, spouse, or any female Eligible Family Member(s), whether or not listed on the application currently pregnant?  
 Yes  No

**Please note:** Coverage under HPN's Individual Plans cannot be issued if you, your spouse, or any female Eligible Family Member (including a dependent child) is now pregnant, unless the pregnant individual is considered HIPAA eligible (See Individual PPO Enrollment Application).

3. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on this application?  
 Yes  No

4. Has anyone applying for healthcare coverage smoked or used any form of a tobacco product within the past twelve (12) months including, but not limited to the following: cigarettes, pipe, cigar, snuff, or chewing tobacco?  
 Yes  No

If yes, who? \_\_\_\_\_  
 a) Pack(s) per day? \_\_\_\_\_ b) How many years? \_\_\_ c) When did he/she stop the tobacco product use? \_\_\_/\_\_\_/\_\_\_

5. Has anyone applying for healthcare coverage consumed alcoholic beverages in any form within the past five (5) years?  
 Yes  No

If yes, who? \_\_\_\_\_  
 Please indicate the number of drinks consumed: \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly  
 (1 drink = 12 oz beer; 4 oz wine; 2 oz liquor)

## INDIVIDUAL MEDICAL QUESTIONNAIRE

6. Within the past five (5) years, has anyone applying for coverage had treatment for, been arrested for, or used any drug which was not prescribed by a physician such as amphetamines or other stimulants, barbiturates or other depressants, cocaine, heroin or other narcotics, LSD or other hallucinogens, marijuana, hashish or tranquilizers?  Yes  No
7. Has anyone applying for coverage ever had his/her driver's license suspended or revoked for driving while intoxicated, or ever been convicted of a felony?  Yes  No

### **PART II**      **HEALTH HISTORY OF YOU AND YOUR FAMILY** **(Include information on ALL Eligible Family Members you wish to cover.)**

Has any person listed on this application within the past five (5) years ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions, diseases or disorders? For each "YES" answer, details must be given in question #23. (All questions must be answered.)

1. Heart/Circulatory System – aneurysm, arteriosclerosis, chest pain, coronary heart disease, elevated cholesterol, heart attack, heart murmur, high or low blood pressure, palpitations, pacemaker, phlebitis, stroke, transient ischemic attacks (TIA), varicose veins, or any other disease or disorder of the heart/circulatory system?  Yes  No
2. Lungs/Respiratory System – allergies, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), difficulty breathing, emphysema, hay fever, pleurisy, pneumonia, pneumothorax, pulmonary embolism, pulmonary tuberculosis, shortness of breath, sinusitis, or any other disease or disorder of the lungs/respiratory system?  Yes  No
3. Brain/Nervous System – Bell's palsy, cerebral palsy, dizziness, epilepsy (convulsions and seizures), fainting spells, mental retardation, migraine headaches, multiple sclerosis, narcolepsy, paralysis, Parkinson's disease, stroke, or any other disease or disorder of brain/circulatory system?  Yes  No  
If epileptic: date of last seizure \_\_\_\_\_
4. Digestive System – cirrhosis, colitis, diarrhea, diverticulitis, fatty liver, gallbladder disease, gastric bypass surgery, gastroesophageal reflux disease (GERD), gastritis, hemorrhoids, hepatitis, hiatal hernia, inflammatory bowel diseases (Crohn's disease, Ulcerative colitis), intestinal problems, pancreatitis, rectal problems, ulcers, or any other disease or disorder of the esophagus, stomach, intestines or liver?  Yes  No
5. Genitourinary System – albuminuria, amenorrhea, cervical dysplasia, cervicitis, cystitis, dysmenorrhea, endometriosis, fibroid tumor, hematuria, hysterectomy, kidney stone, menorrhagia, nephritis, renal failure, renal transplant, urinary incontinence, urinary tract infections, or any other disease or disorder of the urinary system?  Yes  No
6. Skeletal and Muscular System – arthritis, back sprain/strain, bursitis, carpal tunnel syndrome, collagen vascular diseases (connective tissue diseases), fractures, gout, hip disorders, knee disorders, osteoporosis, or any other injury, disease or disorder of the joints, muscles or bones?  Yes  No
7. Nervous and Mental Disorders – alzheimer's, anxiety, anorexia, attention deficit disorder, behavioral problems, bipolar, bulimia, chemical imbalance, depression, eating disorder, emotional problems, or any other nervous and mental disorders?  Yes  No
8. Endocrine/Metabolic System – AIDS or AIDS-Related Complex, anemia, adrenal disorders, diabetes, immune disorders, lupus, Raynaud's, thyroid or any other endocrine/metabolic disease or disorder?  Yes  No
9. Male Reproductive System – disorders of the penis and scrotum, erectile dysfunction, genital herpes, genital warts, gonorrhea, impotency, infertility, prostate, urinary tract infections, sexually transmitted disease (STD), syphilis, or any other male genital disease or disorder?  Yes  No
10. Female Reproductive System – abnormal menstrual bleeding, abortion-miscarriage, breast disorder/cyst, endometriosis, fibroid tumors, genital herpes, genital warts, gonorrhea, infertility, menstruation disorders, ovarian cysts, pelvic pain, sexually transmitted disease (STD), syphilis, or any other female genital disease or disorder?  Yes  No
11. Has anyone applying for healthcare coverage been diagnosed with or treated for cancer, cyst, growth, leukemia, tumors (malignant or benign)?  Yes  No
12. Has anyone applying for healthcare coverage been diagnosed with or treated for cataract, glaucoma, or any other eye disease or disorder?  Yes  No
13. Has anyone applying for healthcare coverage been diagnosed with any physical deformity, birth defect, congenital problems or impairment?  Yes  No
14. Has anyone applying for healthcare coverage been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?  Yes  No
15. Has anyone applying for healthcare coverage been a patient of any hospital, clinic or other medical facility in the past five (5) years?  Yes  No



# INDIVIDUAL MEDICAL QUESTIONNAIRE

By signing this document:

- I understand that Health Plan of Nevada, Inc. (HPN) will acknowledge my application for healthcare coverage with a **verification telephone call**. It is my understanding that this verification call is a routine process for those applying for coverage with HPN and that this telephone call will be recorded. I also understand that my application will not be given further consideration if verification is not completed. I may be contacted at the following number, **between 8:00 a.m. - 4:30 p.m.**:

Preferred Language if other than English: \_\_\_\_\_

Telephone Number: (    ) \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m. Work (    ) Home (    ) Other (    )

Alternate Telephone Number: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m. Work (    ) Home (    ) Other (    )

My spouse (if applying for coverage) may be contacted at the following telephone number:

Telephone Number: (    ) \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m. Work (    ) Home (    ) Other (    )

Alternate Telephone Number: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m. Work (    ) Home (    ) Other (    )

- I represent that all statements and answers made in this document, by whomsoever written including its reverse side and on any attached papers, are true and complete to the best of my knowledge and belief. I agree that this shall be the basis of my acceptance or membership. I realize that any misrepresentation or omission, for any reason, regarding the presence of Preexisting Conditions may result in rescission of my coverage.
- I understand that I am entitled to a copy of this form. Notification of acceptance or rejection of my application will be sent to me by HPN. When the application is accepted, the Effective Date will be indicated.
- I understand that there are Preexisting Condition limitations and waiting periods for certain conditions, except for a guaranteed issue policy under HIPAA. I understand that my coverage and the coverage of my Eligible Family Members may be subject to those exclusions and waiting periods.
- I understand that any omissions or false statements on this Individual Medical Questionnaire may cause an otherwise valid claim to be denied and/or termination of my healthcare coverage or my family's healthcare coverage. If issued, such termination may be made retroactive to the original Effective Date.
- I understand that this form may become a part of my medical records.

I (WE) understand and accept this agreement.

Applicant/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Eligible child's Signature (18 years and over): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Eligible child's 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

HEALTH PLAN OF NEVADA, INC.  
a subsidiary of Sierra Health Services, Inc.

APPLICANT AUTHORIZATION FORM  
(This form is required for new applicants only)

Health Plan of Nevada conditions enrollment on completion of this authorization. You must complete and return this authorization form as part of your application for health coverage.

I hereby authorize any hospital, clinic, institution, physician, or other health care provider to disclose the entire medical record of any Applicant listed herein to the recipient named below. My authority to authorize the disclosure of applicants other than myself is based upon my ability to act as personal representative for the purposes of securing health coverage for the named individuals.

The recipient of the information is Health Plan of Nevada, Inc. This information may be used/disclosed only for the purpose(s) of Medical Underwriting/Risk Assessment. This authorization shall remain in effect for a period of thirty (30) months from the date signed below.

Please list the name of the applicant and all dependents applying for coverage in the spaces below.

_____	_____
Applicant (Print Name)	Dependent #4 (Print Name)
_____	_____
Dependent #1 (Print Name)	Dependent #5 (Print Name)
_____	_____
Dependent #2 (Print Name)	Dependent #6 (Print Name)
_____	_____
Dependent #3 (Print Name)	Dependent #7 (Print Name)

Applicant Signature: \_\_\_\_\_ Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date: \_\_\_\_\_  
Applicant is acting as the personal representative for all dependents listed above.

OR

Signature of Applicant's legally authorized representative (signers other than the applicant must present legal documentation that authorizes them to act on the applicant's behalf)

\_\_\_\_\_ Date: \_\_\_\_\_  
Applicant's Representative Signature

\_\_\_\_\_ Relationship to applicant  
Printed name of applicant's representative

The information you authorize to be disclosed may be re-disclosed by the recipient and the information may no longer be protected under the Federal Privacy Rule. You have the right to revoke any written authorization, except to the extent that we have taken action in reliance on the authorization, by writing to us at Health Plan of Nevada, Inc. Attn. Medical Underwriting Dept., P. O. Box 15645, Las Vegas, NV 89114-5645.

This authorization is voluntary and you may refuse to sign this authorization. However, your failure to complete and return this authorization form will either result in a higher premium rate or prevent us from offering health insurance to you.



S I N C E



1 9 8 2

HEALTH PLAN OF NEVADA, INC.  
a subsidiary of Sierra Health Services, Inc.®

## INDIVIDUAL HMO DEPENDENT CHILD FORM

**IF YOU ARE APPLYING FOR COVERAGE FOR AN ELIGIBLE DEPENDENT CHILD/CHILDREN ONLY, PLEASE COMPLETE THE INFORMATION REQUESTED BELOW.**

I, \_\_\_\_\_, agree to be responsible for the payment of all premiums/refunds due in connection with coverage provided on behalf of the eligible Dependent child/children listed below under the Individual HMO Plan underwritten by Health Plan of Nevada, Inc.

1. \_\_\_\_\_

5. \_\_\_\_\_

2. \_\_\_\_\_

6. \_\_\_\_\_

3. \_\_\_\_\_

7. \_\_\_\_\_

4. \_\_\_\_\_

8. \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Court Appointed Legal Guardian

\_\_\_\_\_  
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.

# HEALTH INSURANCE APPLICATION DISCLOSURE STATEMENT/ACKNOWLEDGEMENT

---

I understand that I must complete, sign and return this Statement/Acknowledgement to Nevada Benefits prior to the start of the insurance application process.

I understand that as an application for health insurance coverage, it may take two weeks (or longer), from the date I have completed and returned my application to **Nevada Benefits** until I am notified as to whether I have been approved for the coverage for which I apply.

I understand that as an applicant for health insurance I am responsible for the cost of medical records should they be requested for the insurance application process.

I acknowledge that neither **Nevada Benefits** nor anyone else employed by or affiliated with **Nevada Benefits** has advised me or even suggested that I cancel or replace any existing insurance policy. Moreover, by executing this Statement/Acknowledgement I am affirmatively stating that I will not cancel any existing insurance coverage, which the policy I am applying for may replace, prior to receiving my approved policy from Nevada Benefits and determining that such policy is satisfactory for my individual needs.

I further agree and understand that should I cancel or replace any existing policy prior to being approved for the policy from Nevada Benefits, that I will be without insurance coverage if the policy for which I have applied is not approved. **Nevada Benefits** does not make underwriting decisions. The insurance company makes all underwriting decisions.

While I have made payment on the policy for which I have applied, I understand that said payment provides conditional coverage only. I also acknowledge that said payment in no way guarantees that my application will be approved. I further acknowledge that even though I have made a payment, I am prohibited by this Statement/Acknowledgement from canceling any existing insurance coverage the **Nevada Benefits'** policy might be replacing until I have first received my approved policy from **Nevada Benefits** and have determined that such policy is satisfactory for my individual needs.

I have read and I understand the pre-existing clause of the policy I have applied for.

Finally, I understand that any person who omits factual information or includes any false or misleading information on an application for insurance will void any insurance coverage, which would otherwise be afforded to me, and I agree to hold **Nevada Benefits** harmless from any claim (including any damages or cause of action) related to any denial of benefits because of any omitted, false, or misleading information, and I acknowledge that I will be responsible to pay all costs (including attorneys' fees) reasonably incurred by **Nevada Benefits** to defend against any such claim or to otherwise enforce the provisions of this document.

Applicant's Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Legal Guardian's Name: \_\_\_\_\_

Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***\*If you would like to receive frequent updates on your underwriting status please provide us with an email address so we may contact you.***

**E-Mail:** \_\_\_\_\_

**THIS DISCLOSURE FORM MUST BE SIGNED AND RETURNED WITH THE ENCLOSED APPLICATION.**