



*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. 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. On the Individual Enrollment Application, choose between Option 1, Option 2 or Option 3, and if dental coverage is desired, check the "Y" box. Fill out this application completely, including the name of your Primary Care Physician (and OB/GYN, if applicable), and sign where indicated.
3. Please fill out the Medical Questionnaire completely. Sign where indicated on the back page.
4. Submit your **first month's premium** by check or money order **made payable to "Health Plan of Nevada"**. Don't forget to add the premium for dental coverage if chosen. You also now have to option to make your initial premium payment by credit or debit card.
5. HPN'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 each month, please include an **additional \$10** to your initial premium payment. 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 initial premium 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 **(702) 258-1995**.

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9505 Hillwood Drive, Suite 100 • Las Vegas, NV 89134 • (702) 258-1995 • Fax (702) 877-0956  
www.nevadabenefits.com • Nevada License # 42429

**Health Plan of Nevada  
Distinct Advantage HMO Plans  
Effective 8/1/2008**

**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	142.00	142.00				
18 - 24	116.00	282.00	398.00	363.00	529.00	675.00
25 - 29	129.00	308.00	437.00	374.00	556.00	710.00
30 - 34	142.00	322.00	462.00	387.00	568.00	734.00
35 - 39	154.00	320.00	473.00	400.00	566.00	742.00
40 - 44	219.00	348.00	565.00	465.00	593.00	825.00
45 - 49	230.00	372.00	602.00	476.00	618.00	858.00
50 - 54	359.00	437.00	797.00	606.00	683.00	1,033.00
55 - 59	487.00	564.00	1,051.00	735.00	810.00	1,264.00
60 - 64	611.00	611.00	1,222.00	857.00	857.00	1,417.00
65+	822.00	872.00	1,694.00	1,068.00	1,119.00	1,842.00

**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	111.00	111.00				
18 - 24	89.00	203.00	291.00	282.00	396.00	511.00
25 - 29	100.00	211.00	312.00	293.00	405.00	530.00
30 - 34	111.00	231.00	341.00	304.00	424.00	557.00
35 - 39	121.00	241.00	363.00	314.00	435.00	574.00
40 - 44	170.00	251.00	419.00	363.00	444.00	627.00
45 - 49	181.00	291.00	472.00	374.00	484.00	675.00
50 - 54	280.00	342.00	623.00	473.00	535.00	810.00
55 - 59	383.00	439.00	822.00	576.00	632.00	988.00
60 - 64	475.00	477.00	953.00	668.00	671.00	1,106.00
65+	642.00	680.00	1,322.00	835.00	873.00	1,440.00

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

**Individual Plan Dental Rider Plan (Optional)**

Age	Male Subscriber	Female Subscriber	Subscriber & Spouse	Male Subscriber & Children	Female Subscriber & Children	Family
0+	33.00	33.00	63.00	89.00	89.00	121.00

**\*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  
Distinct Advantage HMO Plans  
Effective 8/1/08**

**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	161.00	161.00				
18 - 24	130.00	320.00	451.00	412.00	603.00	770.00
25 - 29	147.00	349.00	496.00	429.00	631.00	809.00
30 - 34	161.00	363.00	524.00	443.00	644.00	834.00
35 - 39	174.00	363.00	536.00	456.00	644.00	845.00
40 - 44	245.00	395.00	640.00	526.00	676.00	937.00
45 - 49	259.00	421.00	679.00	541.00	702.00	973.00
50 - 54	408.00	492.00	899.00	690.00	773.00	1,173.00
55 - 59	552.00	638.00	1,190.00	834.00	920.00	1,434.00
60 - 64	691.00	690.00	1,380.00	972.00	971.00	1,604.00
65+	930.00	986.00	1,916.00	1,211.00	1,269.00	2,087.00

**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	107.00	107.00				
18 - 24	86.00	195.00	282.00	274.00	383.00	495.00
25 - 29	98.00	205.00	303.00	284.00	391.00	512.00
30 - 34	107.00	222.00	328.00	293.00	409.00	535.00
35 - 39	117.00	232.00	350.00	304.00	419.00	556.00
40 - 44	164.00	242.00	407.00	351.00	429.00	606.00
45 - 49	175.00	282.00	457.00	363.00	469.00	652.00
50 - 54	271.00	330.00	602.00	459.00	517.00	783.00
55 - 59	370.00	424.00	794.00	557.00	611.00	955.00
60 - 64	460.00	462.00	922.00	646.00	649.00	1,070.00
65+	620.00	658.00	1,277.00	807.00	845.00	1,389.00

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

**Individual Plan Dental Rider Plan (Optional)**

Age	Male Subscriber	Female Subscriber	Subscriber & Spouse	Male Subscriber & Children	Female Subscriber & Children	Family
0+	33.00	33.00	63.00	89.00	89.00	121.00

**\*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 Benefits at a Glance

Distinct Advantage Plans	HMO - Option 1 maternity coverage (12-month wait)	HMO - Option 2 maternity coverage excluded	Point of Service - Option 3 maternity coverage (12-month wait)			HMO - Option 4 maternity coverage excluded	
			HMO - Tier I	Expanded Plan Tier II	Non-Plan Tier III		
<b>Lifetime Maximum Benefit</b>	\$1,000,000	\$1,000,000	Unlimited	\$1,000,000		\$1,000,000	
<b>Calendar Year Deductible (CYD)</b>	not applicable	not applicable	not applicable	\$500 per Member/\$1,500 per Family		not applicable	
<b>Annual Copay/Coinsurance Maximum</b>	\$2,000 per Member \$4,000 per Family	\$4,000 per Member \$8,000 per Family	not applicable	\$2,000 per Member \$6,000 per Family	\$4,000 per Member \$12,000 per Family	\$5,000 per Member \$10,000 per Family	
<b>Physician Services</b>					After CYD, you pay 40% of EME and all charges in excess of EME		
Primary Care Provider	\$10 per visit	\$25 per visit	\$15 per visit	\$30 per visit		\$25 per visit	
Specialist	\$20 per visit	\$50 per visit	\$30 per visit	\$45 per visit		\$50 per visit	
Well-child and Preventive Care	\$10 per visit	\$10 per visit	\$15 per visit	20% of EME*		\$10 per visit	
<b>Diagnostic Services</b>					After CYD, you pay 40% of EME for lab and 30% of EME for x-ray and all charges in excess of EME		
Routine Laboratory	\$10 per visit	\$10 per visit	\$15 per visit	\$15 per visit		\$15 per visit	
Routine X-ray	\$10 per visit	\$10 per visit	\$15 per visit	\$15 per visit		\$15 per visit	
<b>Hospitalization - Elective Procedures</b>					After CYD, you pay 40% of EME and all charges in excess of EME		
Inpatient	\$100 per day (not to exceed \$300 per admission)	\$300 per day (not to exceed \$900 per admission)	\$150 per day (not to exceed \$400 per admission)	After CYD, you pay 20% of EME		\$300 per day (not to exceed \$900 per admission)	
Outpatient	\$75 per admission	\$200 per admission	\$75 per admission			\$200 per admission	
<b>Physician Surgical Services</b>					After CYD, you pay 40% of EME and all charges in excess of EME		
Inpatient Hospital	\$100 per surgery	\$200 per surgery	\$100 per surgery	After CYD, you pay 20% of EME		\$200 per surgery	
Outpatient Facility	\$75 per surgery	\$200 per surgery	\$75 per surgery			\$200 per surgery	
Physician's Office							
Primary Care Provider	\$10 per visit	\$25 per visit	\$15 per visit			\$25 per visit	
Specialist	\$20 per visit	\$50 per visit	\$30 per visit			\$50 per visit	
Anesthesia	\$100 per surgery	\$100 per surgery	\$100 per surgery	\$100 per surgery	\$100 per surgery		
<b>Emergency Services, within service area</b>					Emergency services are covered under the HMO - Tier I benefit		
Emergency Room	\$75 per visit; <i>waived if admitted</i>	\$75 per visit; <i>waived if admitted</i>	\$75 per visit	Emergency services are covered under the HMO - Tier I benefit	Emergency services are covered under the HMO - Tier I benefit	\$75 per visit; <i>waived if admitted</i>	
Physician Services	\$25 per visit	\$25 per visit	\$25 per visit			\$25 per visit	
Hospital Admission	\$100 per day (not to exceed \$300 per admission)	\$300 per day (not to exceed \$900 per admission)	\$150 per day (not to exceed \$400 per admission)			\$150 per day (not to exceed \$400 per admission)	
Ground Ambulance (when medically necessary)	\$150 per trip	\$150 per trip	\$150 per trip			\$150 per trip	
Urgent Care - Southwest Medical Associates	\$45 per visit	\$45 per visit	\$45 per visit			\$45 per visit	
-Other Plan Provider	\$50 per visit	\$50 per visit	\$50 per visit			\$50 per visit	
-Non-plan Provider	\$60 per visit	\$60 per visit	\$60 per visit	\$60 per visit			
<b>Emergency Services, outside service area</b>					Emergency services are covered under the HMO - Tier I benefit		
Emergency Room	\$150 per visit; <i>not waived if admitted</i>	\$150 per visit; <i>not waived if admitted</i>	\$150 per visit	Emergency services are covered under the HMO - Tier I benefit	Emergency services are covered under the HMO - Tier I benefit	\$150 per visit; <i>not waived if admitted</i>	
Physician Services	\$75 per visit	\$75 per visit	\$75 per visit			\$75 per visit	
Hospital Admission	\$100 per day (not to exceed \$300 per admission)	\$300 per day (not to exceed \$900 per admission)	\$150 per day (not to exceed \$400 per admission)			\$150 per day (not to exceed \$400 per admission)	
Ground Ambulance (when medically necessary)	\$150 per trip	\$150 per trip	\$150 per trip			\$150 per trip	
Urgent Care	\$60 per visit	\$60 per visit	\$60 per visit			\$60 per visit	
<b>Mental Health Services</b>					After CYD, you pay 40% of EME and all charges in excess of EME		
Outpatient Group Therapy	\$10 per visit	\$25 per visit	\$15 per visit	After CYD, you pay 20% of EME		\$25 per visit	
<b>Vision Services</b>							
Preventive Exam <small>(one per Member during each 12 consecutive month period)</small>	\$10 per visit	\$10 per visit	\$10 per visit	not covered	not covered	\$10 per visit	

**Option 1 and Option 3 include a 12-month waiting period for maternity coverage. Option 2 and Option 4 do not include maternity coverage. \*EME (Eligible Medical Expenses) means the maximum amount the Plan will pay for a Covered Service or Covered Drug in accordance with the Plan Reimbursement Schedule. Under Option 3, members are responsible for all amounts exceeding the Plan's EME payment when charges are billed by Non-Plan Providers. Charges in excess of maximum benefit payments and EME may be substantial.**

A comprehensive description of the Plan benefits, exclusions and limitations are listed in the Individual Distinct Advantage HMO and PPO Agreements, Coverage, Attachment A Benefit Schedules and applicable Endorsements, Disclosure Summaries and Riders. Copies of these current Plan documents are available upon request. Maximum benefits apply to certain covered services. Plan documents govern in resolving any benefit questions or payments.

# Prescription Drug Rider

Options 1, 2, 3, 4	Up to a 30-day therapeutic supply
Preferred Generic Drug	\$7
Preferred Brand Name Drug (when no Generic is available)	\$30
Preferred Brand Name Drug (when Generic is available)	\$7 plus the difference between the EME* of the Generic and the EME of the Brand Name
Non-Preferred Generic or Brand Name Drug	\$50
Preferred Mail Order Maintenance Drug	Up to a 90-day maintenance supply. Member pays twice the applicable copayment
Note: Please refer to the prescription drug benefit rider for a complete list of all copayment amounts and applicable limitations and exclusions. Form No. HPN-NV-Ind-3TierSIO-2003	

# Optional Dental Rider

Calendar Year Deductible	none
Maximum Calendar Year Benefit	\$1,000
<b>Covered Services</b>	<b>You Pay</b>
<b>Preventive and Diagnostic Services</b> (Type I Services) Examinations (two per calendar year) Emergency exam Cleaning (two per calendar year) Periapical X-ray Bitewing X-rays (two per calendar year) Full mouth X-rays or panorex (once per calendar year) Fluoride treatment (one per calendar year in combination with cleaning)	no charge \$10 per exam no charge no charge no charge \$15 no charge
<b>Basic Services</b> (Type II Services) Available after six months continuous coverage under this rider. Restorative (fillings) Periodontics Root canal therapy Tooth extraction (includes local anesthesia) Repairs to: Partial, denture, crown or bridgework	\$10 per tooth \$10-\$200 (depending on services) \$75 per tooth \$10-\$25 per tooth \$10-\$37 (depending on services)
<b>Major Services</b> (Type III Services) Available after twelve months continuous coverage under this rider. Crowns or bridgework  Complete upper or lower denture Immediate upper or lower denture Upper or lower partial denture	\$152-\$180 per tooth (depending on materials used) \$210 per denture \$235 per denture \$202-\$240 per denture (depending on materials used) \$38-\$64 per appliance
Note: Please refer to the dental rider for a complete list of all copayment amounts and applicable limitations and exclusions. Form No. HPN-IND-DENT (Revised 98)	

## Dental

Dental coverage is available for an additional monthly premium. We provide an extensive list of dental providers and cover many of the services you and your family may need.



**HEALTH PLAN OF NEVADA, INC.**

a subsidiary of Sierra Health Services, Inc.®

Area for HPN use only:

Declined  Accepted  Effective Date: \_\_\_/\_\_\_/\_\_\_

Date Processed \_\_\_/\_\_\_/\_\_\_ Underwriter \_\_\_

**Individual HMO Enrollment Application Form**

Please mark your selection.

Option 1 (HMO)  Option 2 (HMO)  Option 3 (POS)  Option 4 (HMO)

\*12-month MWP \*No Maternity Coverage \*12-month MWP \*No Maternity Coverage

Direct Bill  Sure Pay (AutoPay)

Dental: Yes \_\_\_ No \_\_\_ Vision: Yes \_\_\_ No \_\_\_

Optional for all Individual Plans

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed Date of Marriage: \_\_\_

Applicant Name: \_\_\_ Social Security No. \_\_\_

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: (\_\_\_) \_\_\_

**HIPAA Plans:** 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.

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#	Primary Physician	OB/GYN (For Females)*
				Applicant				

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

Health Plan of Nevada, Inc., ("HPN") 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 Members in the same class. In addition, an increase will be applied if a Member has a birthday that results in an age reclassification on the rate charts. Applications 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.





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					
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.

(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.



# HEALTH PLAN OF NEVADA, INC.<sup>SM</sup>

A subsidiary of Sierra Health Services, Inc.

## AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS

Applicant's name:	Name of account holder(s):
Applicant's social security number:	SS# of other account holder (s):
Street address:	
City:	State: Zip:
Telephone number - home:	Telephone number - business:
E-mail Address - home:	E-mail Address - business:
Bank name:	Bank branch:
Bank address:	
Account number:	Type of account: <input type="checkbox"/> checking <input type="checkbox"/> savings

As a convenience to me, I (we) authorize Health Plan of Nevada, Inc. (HPN) to initiate debit entries to the account listed above at the bank or credit union (institution) listed above **equal to the monthly premium** for The Personal Choice Plan from Health Plan of Nevada, Inc.

**This authorization is to remain in full force and effect until HPN and the institution have received written notification from me (or either of us) of its termination in such a manner as to afford HPN and the institution a reasonable opportunity to act on it.** I (or either of us) have the right to stop payment of a debit entry by notification to the institution prior to charging the account.

After the account has been charged, I (we) have the right to have the amount of an erroneous debit immediately credited to my (our) account by the institution, provided I (we) send written notice of the error to the institution within 15 days of the issuance of the account statement or 45 days after posting, whichever occurs first. Should this right be exercised, I (we) will notify HPN prior to such action to make arrangements for continuation or termination of coverage.

*Please note:*

1. Your application will not be processed without a **pre-printed voided check** from which monthly premiums are to be withdrawn.
2. After application has been successfully processed by HPN, a confirmation letter will be sent to you.
3. In the event your monthly premiums increase, (at renewal or due to a change in age bracket), the increased premium rate will be deducted from your account.

**X**

**X**

Signature of depositor(s) as appears on bank records

Date



HEALTH PLAN OF NEVADA, INC.<sup>SM</sup>

a subsidiary of Sierra Health Services, Inc.<sup>®</sup>

**INDIVIDUAL  
DISTINCT ADVANTAGE – 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 Distinct Advantage 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 from four to six 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 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: \_\_\_\_\_

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

Applicant/Guardian's Signature: \_\_\_\_\_

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

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