

ENROLLMENT FORM



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



SIERRA HEALTH AND LIFE
INSURANCE COMPANY, INC.
a subsidiary of Sierra Health Services, Inc.

HMO benefits are underwritten by Health Plan of Nevada, Inc. Life, AD&D, Vision, and Dental Insurance benefits are underwritten by Sierra Health and Life Insurance Company, Inc.

PLEASE TYPE OR PRINT IN BLACK BALL-POINT AND PRESS HARD FOR 3 COPIES. SHADED AREAS FOR HOME OFFICE USE.

Employer Name UNSON		Name: Last First M.I.			Social Security No.		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Effective Date	
Date of Birth / /	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Mailing Address: Street Apt. No. City State Zip			Home Phone ()				Group No. 10001519	
Occupation/Title		Date of Hire* Full-Time / /	Employer I.D. No. (if applicable)	Work Phone ()		Annual Salary	Have you previously been a Member of HPN? <input type="checkbox"/> Yes <input type="checkbox"/> No		Coverage	
HPN Primary Care Provider Code**	I am enrolling in the following coverage (if offered by my employer) from HPN: <input type="checkbox"/> HMO Medical <input type="checkbox"/> POS Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision SHL: <input type="checkbox"/> Life <input type="checkbox"/> Dental <input type="checkbox"/> Vision	I am enrolling my Eligible Family Member(s) in the following coverage (if offered by my employer) from HPN: <input type="checkbox"/> HMO Medical <input type="checkbox"/> POS Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision SHL: <input type="checkbox"/> Life <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If Medicare Eligible (check) <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Who should we contact in case of emergency? (please provide name and daytime/business phone number)		Personal e-mail address:		Class Code	
HPN OB/GYN Provider Code**	Supplemental Life COBRA <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date:									
*If the employee is reclassified to full-time status, please provide the date of full-time employment. **Refer to Primary Care Provider list. Enter the number found next to the provider you choose as a Primary Care Provider. Important: Females may choose two (2) HPN Primary Care Physicians; one (1) Physician for medical care and one (1) for OB/GYN.										

ELIGIBLE FAMILY MEMBER(S) INFORMATION (Complete only if Dependent coverage is desired)

Relation to Applicant	Last Name	First	MI	DOB Mo/Day/Yr	Sex M/F	Social Security Number	Full-Time Student Status	HPN Primary Care Provider Code**	HPN OB/GYN Provider Code** (if applicable)
Spouse							<input type="checkbox"/> Yes <input type="checkbox"/> No	--	--
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	--	--
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	--	--
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	--	--
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	--	--
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	--	--

IMPORTANT: THIS SECTION MUST BE COMPLETED

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.

1. Are you or any of your Eligible Family Member(s) covered by a health insurance Plan, Medicare or Medicaid now or in the past 18 months?
 Yes No If "yes" is checked, please complete the following:

A.) Carrier's name: _____ B.) Effective date: _____ C.) Termination date: _____
 D.) Type of Coverage: Life Medical Dental Vision Pharmacy E.) Active employee Retirement benefits
 F.) Single Family If family, list names of Eligible Family Member(s) covered: _____

2. Name of spouse and/or Eligible Family Member(s) who are currently employed: _____

A. Social Security No.: _____ B. Date of Birth: _____
 C. Employer Name: _____ D. Employer's Telephone No.: _____

Life insurance primary beneficiary designation information (when offered by my employer):

Supplemental Life amount required (if offered):\$ _____

1- Name: Last First M.I. Relationship

 Address: Street City State Zip

2- Contingent Beneficiary: Name and Relationship

3- Was a Medical Questionnaire completed? Yes No

I understand that my Authorized Representative or I am entitled to a copy of this form upon request. I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. I agree that they shall be used as the basis of acceptance for coverage of me and my Eligible Family Member(s) (if any). I realize that any intentional or material misrepresentation or omission regarding eligibility for coverage may result in rescission of my coverage.

Employee Signature (Signature for self and Eligible Family Member(s))

DATE

Authorized Signature/Employer (if required)

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.