

HPN HMO Submission Checklist

1. **1st month premium must be included to be processed**
Equal to 1st months premium in either check, money order made payable to **HPN** or Credit Card
Payment + \$10.00 if you would like to be billed direct

2. **Enrollment Application Form**
All information completed
Requested Effective Date (1st or the 15th of each month)
Signed and dated by Applicant (older spouse must be the applicant)

3. **Medical Questionnaire**
All questions must be answered
Verification phone number included
Signed and dated by application (and spouse if applicable)

4. **Application Authorization Form** completed by primary applicant

5. **Authorization for PreArranged Payments**
Payments will be withdrawn automatically from a checking or savings account monthly beginning with the second month of coverage.
All information completed, signed and dated

6. **Void Check** – If authorizing payments to be drafted from account

7. **Dependent Child Form** –
Required for individual policy for child only under age 17

8. **Mail all Completed Applications to:**
George Gay
GGA Insurance Services
PO Box 91568
Henderson NV 89009-1568

Completed applications must be received by the Sierra Health & Life Insurance Co 7 days PRIOR to requested effective date (1st or the 15th effective dates). Please indicate requested effective date on the Enrollment Application Form. If no requested effective date is requested, the 1st of the following month will be used. **Once received, Medical Underwriting will call to complete a Telephone Verification Interview within approximately 7 days of receipt of application.**

If you have any questions, please contact your broker:

George Gay
PH: 702-565-7875
email: george@nvquote.com

Area for HPN use only:

Declined Accepted Effective Date: ____/____/____
 Date Processed ____/____/____ Underwriter _____

Individual HMO Enrollment Application Form

Direct Bill Sure Pay (AutoPay)

Please mark your selection.	<input type="checkbox"/> Option 1 (HMO) *12-month MWP	<input type="checkbox"/> Option 2 (HMO) *No Maternity Coverage	<input type="checkbox"/> Option 3 (POS) * 12-month MWP	<input type="checkbox"/> Option 4 (HMO) *No Maternity Coverage	Dental: ____ Yes ____ No Optional for all Individual Plans	Vision: ____ Yes ____ No
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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: _____
 Name 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)*	ESD#
				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.

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.SM
a subsidiary of Sierra Health Services, Inc.^{SC}

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

 Printed name of applicant's representative Relationship to applicant

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.SM

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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

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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.