SINCE 1982

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.

individual plans

individual plans

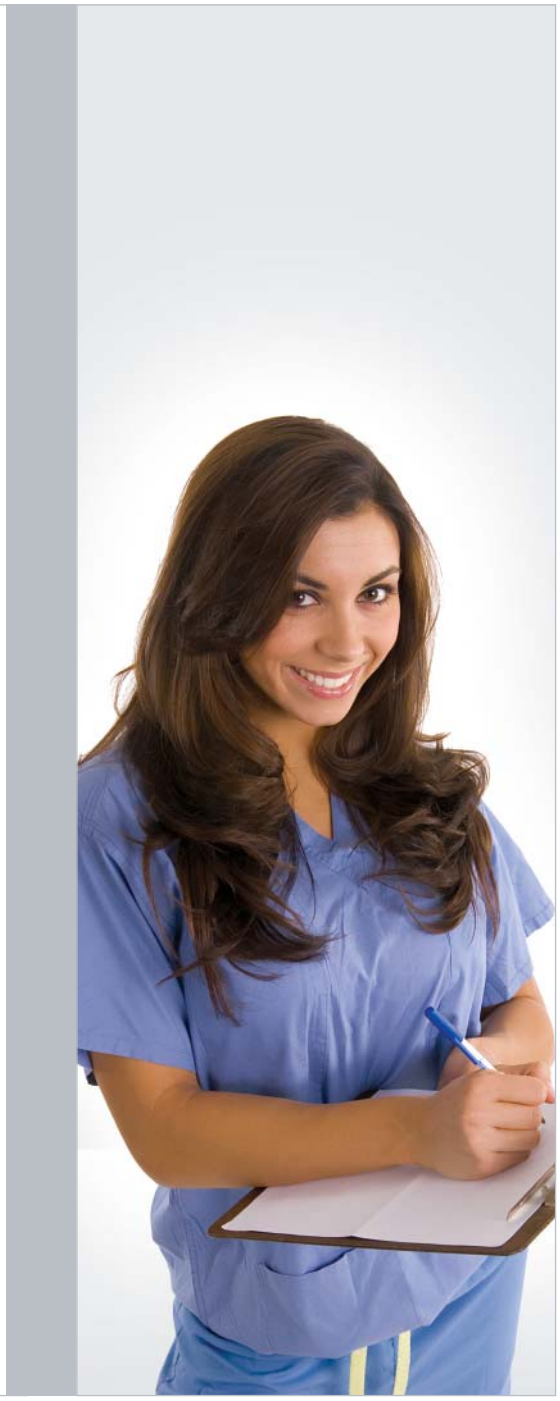
quality, convenience and choices

When you select a health plan from Health Plan of Nevada or Sierra Health and Life, you have access to care around-the-clock. We're confident that you will find a health plan that's just right for you.

Health Plan of Nevada offers three Health Maintenance Organization (HMO) medical plans and one Point of Service (POS) medical plan offering a selection of qualified physicians, hospitals, pharmacies and other providers to choose from.

Sierra Health and Life offers four Preferred Provider Organization (PPO) medical plans. These plans let you choose from an extensive group of providers with a sense of comfort and security.

Listed below is an overview of the many benefits and services you will enjoy when you enroll in one of our individual health plans. We invite you to take a look at the information in this booklet, and you'll see that joining Health Plan of Nevada or Sierra Health and Life is a good decision.



Health Plan of Nevada and Sierra Health and Life offer:

- ✓ Comprehensive benefits for provider office visits, hospitalization, prescription drugs and preventive care
- ✓ Extensive provider networks
- ✓ Confidential online member center
- ✓ 24-Hour Telephone Advice Nurse Service
- ✓ Predictable, affordable copayments for most covered services

If you have questions or would like additional information, please call our sales office at

702-821-2200 or toll-free at 800-873-0004.

We thank you for your interest in our Individual Plans.

Understand the Services Available to You

We know that when selecting a health plan, you want to know how the plan works. We also know that you rely on us to provide appropriate and easily accessible services. This section will give you additional information on why our Individual Plans are a good choice for you and your family.

Online Member Service Center – 24 Hours a Day

When you enroll with Health Plan of Nevada or Sierra Health and Life, you'll have access to an exciting online member center. You'll be surprised at how easy it is to get answers to claims and benefit questions, as well as access some service features. And, because it's through your computer, We're@YourService℠ is available around-the-clock at **www.healthplanofnevada.com** and **www.sierrahealthandlife.com**. You will feel secure knowing that your medical information is confidential and is only available to you and your provider.

Hospital Care

When you need elective hospital care, your plan provider will assist in coordinating those services. You should refer to the *Benefits at a Glance* sections for applicable copayments or deductibles and coinsurance, related to hospital visits, physician services and anesthesia. In a true emergency or life-threatening situation, call 911 or go to the nearest hospital emergency room.

Health Education and Wellness Programs

Health Plan of Nevada and Sierra Health and Life are always looking to the future. That's why we believe in preventive health care and helping you to achieve the best health possible. To keep you on the right track, our Health Education and Wellness Division offers information and programs on a variety of disease management and healthy living topics. You can contact the Health Education and Wellness Division at **(702) 877-5356** or toll-free **(800) 720-7253** for additional information. Program availability varies by state and region.

Access Care Day or Night

Health Plan of Nevada and Sierra Health and Life hope you never have to receive emergency services. But if you do, and the condition is life-threatening, call 911 immediately. When it is not, we encourage you to contact your plan provider or the Telephone Advice Nurse service. If your provider's office is closed and the Telephone Advice Nurse suggests you seek care from an urgent care facility or emergency room, please do so. We have provided some general information below that may assist you when faced with this type of situation.

24-hour Telephone Advice Nurse Service

It doesn't matter if it's day or night, a holiday or weekend, our free Telephone Advice Nurse service is open to provide helpful advice about simple medical concerns. Depending on your situation, a licensed registered nurse will help you decide whether to seek urgent care or wait until the next day to see your provider. When you have health questions or concerns, call our Telephone Advice Nurse service at **(702) 242-7330** or **(800) 288-2264**.

Urgent Care

Urgent Care is available at several convenient locations and is recommended for conditions that don't require immediate emergency care, but cannot wait until your provider's regular office hours. This may include ear infections, colds and other respiratory problems, abdominal pain, vomiting, diarrhea, back pain, sprains and strains. When possible, consider how serious your medical condition is. If your condition is not life-threatening, the plan will pay benefits only if you get care from an urgent care facility or from your plan provider.

Contracted Urgent Care Facilities (Southern Nevada)

Southwest Medical Associates	2704 N. Tenaya Way, Las Vegas 89128
Southwest Medical Associates	2845 Siena Heights Dr., Henderson 89052
Southwest Medical Associates	4475 S. Eastern Ave., Las Vegas 89119
Southwest Medical Associates (open 24 hours)	888 S. Rancho Dr., Las Vegas 89106
UMC Quick Care	1700 Wheeler Peak St., Las Vegas 89106
UMC Quick Care	1769 E. Russell Rd., Las Vegas 89119
UMC Quick Care	2031 N. Buffalo Dr., Las Vegas 89128
UMC Quick Care	2202 W. Craig Rd., N. Las Vegas 89032
UMC Quick Care	4180 S. Rainbow Blvd. #810, Las Vegas 89103
UMC Quick Care	4333 N. Rancho Dr., Las Vegas 89130
UMC Quick Care	525 Marks St., Henderson 89014
UMC Quick Care	5412 Boulder Hwy., Las Vegas 89122
UMC Quick Care	61 N. Nellis Blvd., Las Vegas 89110
UMC Quick Care	9320 W. Sahara Ave., Las Vegas 89117
Advanced Medical Center	1501 E. Calvada Blvd., Pahrump 89048

Emergency Care

Health Plan of Nevada and Sierra Health and Life cover emergency services around-the-clock. If you experience a life-threatening condition, please call 911 immediately or go to the nearest hospital emergency room. For emergency situations, it is not necessary to contact your provider or the Plan to obtain authorization for care. Emergency room care is needed for such conditions as severe chest pain, serious burns, major trauma, poisoning, heavy bleeding or sudden paralysis. When your medical condition is not life-threatening and you visit an emergency room, you could have to pay the entire amount of the charges. These charges include services from the hospital and the doctor.

Contracted Hospitals (Southern Nevada)

Desert Springs Hospital Medical Center	2075 E. Flamingo Rd., Las Vegas 89119
North Vista Hospital	1409 E. Lake Mead Blvd., Las Vegas 89030
Spring Valley Hospital Medical Center	5400 S. Rainbow Blvd., Las Vegas 89118
St. Rose Dominican Hospital (Rose de Lima Campus)	102 E. Lake Mead Pkwy., Henderson 89015
St. Rose Dominican Hospital (Siena Campus)	3001 St. Rose Pkwy., Henderson 89052
St. Rose Dominican Hospital (San Martín Campus)	8280 W. Warm Springs Road, Las Vegas 89113
Summerlin Hospital Medical Center	657 N. Town Center Dr., Las Vegas 89144
University Medical Center	1800 W. Charleston Blvd., Las Vegas 89102
Valley Hospital Medical Center	620 Shadow Ln., Las Vegas 89106
Desert View Regional Medical Center	360 S. Lola Ln., Pahrump 89048
Boulder City Hospital	901 Adams Blvd., Boulder City 89005

For a complete list of urgent care facilities and hospitals in Northern and Southern Nevada, please refer to your provider directory.

Health Plan of Nevada
Individual HMO and POS Plans

Health Plan of Nevada, Inc., has been awarded an accreditation status of Commendable from the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to measuring the quality of America's health care. Accreditation is for the Commercial HMO, Commercial POS and Medicare HMO product lines in Nevada effective May 2006.

Online. Anytime.
We're@YourService℠
www.healthplanofnevada.com

Member Services

(702) 242-7300 or **(800) 777-1840**

Confidentiality of Member Information

Health Plan of Nevada is careful to protect your privacy by developing operational policies and procedures for the way we work with other companies. Currently, Health Plan of Nevada instructs all employees on confidentiality procedures.

We share protected health information (PHI) only with individuals or entities as necessary to coordinate your health care or administer your health benefits. When you enroll in one of our plans, we may use your PHI for future, known or routine purposes, such as treatment or conducting quality assessments. And, of course, we share PHI in accordance with state and federal law.

Health Plan of Nevada uses security precautions to protect PHI or data about you containing personal facts and health information that is personally identifiable, either implicitly or explicitly. We also require our contracted providers to take similar steps to protect your PHI. Health Plan of Nevada does not share your PHI, unrelated to plan administration, with employers unless we have your authorization.

We use medical data to promote and improve the quality of care you receive. When conducting research and measuring quality, Health Plan of Nevada uses summary information whenever possible, not PHI. When we do use PHI, steps are taken to help protect it from inappropriate disclosure. We do not allow PHI to be used for research by organizations outside Health Plan of Nevada without your consent.

You have the right to access your medical records and can do so by contacting your provider of care. When you request specific medical records be shared with others, Health Plan of Nevada may require you to sign an authorization form. We may also ask you for special consent for non-routine uses of your personal data. Of course when we ask you for authorization to release your PHI, you have the right to refuse. In addition to authorizing us to release your PHI, this extra step helps you understand why your PHI will be shared. When a member/insured lacks the ability to authorize a release, we obtain authorization from persons recognized by state or federal laws to give such authorization.

HMO Option 1 & POS Option 3

Glad you Asked!

Q. Health Plan of Nevada's Distinct Advantage Plans HMO Option 1 and POS Option 3 have a 12-month waiting period for maternity coverage. Please define "Maternity Waiting Period."

A. The 12-month waiting period begins on the effective date of coverage. For example, if coverage for a member begins on January 1, 2006, any services or supplies provided in connection with pregnancy or childbirth will be covered on or after January 1, 2007.

Q. What claims, if any, would be paid for services and supplies during the 12-month waiting period?

A. Only claims related to complications of pregnancy will be allowed during the first 12 months of coverage.

Q. If a member gets pregnant during the 12-month waiting period and delivers after 12 months, what claims would be paid?

A. Claims for delivery will be paid if the member delivers no sooner than day 366 after her effective date.

Q. What if there are complications of pregnancy during the waiting period?

A. Complications of pregnancy are a covered benefit just like any other medical service during the waiting period.

Choose Health Plan of Nevada

Our Individual HMO plans are designed to give you the most benefits for the least out-of-pocket costs. We also offer an Individual POS plan designed to give you competitive benefits with flexibility. When you access non-emergency care under the POS plan, you have a choice of benefit levels each and every time. Take a look at the Health Plan of Nevada *Benefits at a Glance* section of this brochure. This snapshot provides you with copayments for the services most members refer to when making health care decisions. To find out more about how our Individual HMO and POS plans work, review all the material we've presented to you. We are confident that you'll find our plans are right for you and your family!

Prescription Drug Benefits

If you enroll with us, you'll have access to a wide range of effective and affordable prescription medications. We maintain a Preferred Drug List, so when your Health Plan of Nevada provider makes a selection from this list, your out-of-pocket cost is lower. You also have coverage for medications not included on our Preferred Drug List. Please refer to your Prescription Drug Rider for specific information about the plan available to you. If you would like a copy of the Preferred Drug List, call our Member Services Department or visit the Health Plan of Nevada website at **www.healthplanofnevada.com**.

The Life Connection Comprehensive Member Assistance Program

Health Plan of Nevada members have access to The Life Connection. This service includes a member assistance program, visits with a professional counselor and a variety of information and resources including: legal issues, financial management, emotional well-being and much more.

Dental and Vision (Dental benefits available in Southern Nevada only)

Enrolled members also have access to dental and vision care services through Health Plan of Nevada. For a summary of covered services and copayment amounts, refer to the *Benefits at a Glance* section of this brochure.

Select Quality Providers

Your Primary Care Provider

When you select your Primary Care Provider (PCP), you are selecting the leader of your health care team. Your PCP will play a vital role in coordinating the care and services you may need. Because your PCP is so important, Health Plan of Nevada has a wide selection of providers to choose from. When enrolling, Health Plan of Nevada will ask you to choose a PCP for you and your family. Each family member may select his or her own PCP, or the entire family may choose the same provider. Female members will also select an OB/GYN Primary Care Provider. To assist you with your provider selection, provider directories are available online at **www.healthplanofnevada.com**. When you are ready to make an appointment, simply contact your PCP's office.

Southwest Medical Associates (Southern Nevada only)

We understand that quality and convenience are important when selecting a provider. Therefore, we contract with Southwest Medical Associates, Nevada's largest multispecialty medical group. With over 200 providers, they offer same-day appointments and extended office hours. And for your convenience, many of their locations have on-site laboratory and radiology services. For more information, visit **www.smalv.com** or call **(702) 877-5199** for an appointment.

Specialists

We make it easy to see a specialist. As with all your health care, your PCP will assist you in determining if specialty care is needed. If you select an HMO plan, your PCP will provide you with a specialist referral, and once you receive a referral, you may select a specialist from your provider directory. With the POS plan, you may access a specialist directly, without a referral.

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	
Lifetime Maximum Benefit	$1,000,000	$1,000,000	Unlimited	$1,000,000		$1,000,000
Calendar Year Deductible (CYD)	not applicable	not applicable	not applicable	$500 per Member/$1,500 per Family		not applicable
Annual Copay/Coinsurance Maximum	$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
Physician Services						
Primary Care Provider	$10 per visit	$25 per visit	$15 per visit	$30 per visit	After CYD, you pay 40% of EME and all charges in excess of EME	$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
Diagnostic Services						
Routine Laboratory	$10 per visit	$10 per visit	$15 per visit	$15 per visit	After CYD, you pay 40% of EME for lab and 30% of EME for x-ray and all charges in excess of EME	$15 per visit
Routine X-ray	$10 per visit	$10 per visit	$15 per visit	$15 per visit		$15 per visit
Hospitalization - Elective Procedures						
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	After CYD, you pay 40% of EME and all charges in excess of EME	$300 per day (not to exceed $900 per admission)
Outpatient	$75 per admission	$200 per admission	$75 per admission			$200 per admission
Physician Surgical Services						
Inpatient Hospital	$100 per surgery	$200 per surgery	$100 per surgery	After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess 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
Emergency Services, Plan Provider						
Emergency Room	$75 per visit; *waived if admitted*	$75 per visit; *waived if admitted*	$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; *waived if admitted*
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)			$300 per day (not to exceed $900 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
Emergency Services, Non-Plan Provider						
Emergency Room	$150 per visit; *not waived if admitted*	$150 per visit; *not waived if admitted*	$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; *not waived if admitted*
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)			$300 per day (not to exceed $900 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
Mental Health Services						
Outpatient Group Therapy	$10 per visit	$25 per visit	$15 per visit	After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess of EME	$25 per visit
Vision Services						
Preventive Exam (one per Member during each 12 consecutive month period)	$10 per visit	$10 per visit	$10 per visit	not covered	not covered	$10 per visit

Form No. HPN-IndDAP-masBS-2005 (Option 1, 2 & 4), Form No. HPN-IndDAP3-BS-2005 (Option 3), Form No. HPN VIS PREV(1/93) [vision]

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 Agreement of Coverage, Attachment A Benefit Schedules and applicable Endorsements, Disclosure Summaries and Riders. Copies of these 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	$10
Preferred Brand Name Drug*	$35
Non-Preferred Generic or Brand Name Drug*	$60
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.

*If a Generic Covered Drug equivalent is available, member pays the $10 copay plus the difference between the EME of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Plan Pharmacy for each therapeutic supply.

Form No. HPN-NV-Ind-3TierSIO-2003

Optional Dental Rider (Available in Southern Nevada only)

Calendar Year Deductible	none
Maximum Calendar Year Benefit	$1,000
Covered Services	You Pay
Preventive and Diagnostic Services (Type I Services)	
Examinations (two per calendar year)	no charge
Emergency exam	$10 per exam
Cleaning (two per calendar year)	no charge
Periapical X-ray	no charge
Bitewing X-rays (two per calendar year)	no charge
Full mouth X-rays or panorex (one per calendar year)	$15
Fluoride treatment (one per calendar year in combination with cleaning)	no charge
Basic Services (Type II Services) Available after six months continuous coverage under this rider.	
Restorative (fillings)	$10 per tooth
Periodontics	$10-$200 (depending on services)
Root canal therapy	$75 per tooth
Tooth extraction (includes local anesthesia)	$10-$25 per tooth
Repairs to: Partial, denture, crown or bridgework	$10-$37 (depending on services)
Major Services (Type III Services) Available after 12 months continuous coverage under this rider.	
Crowns or bridgework	$152-$180 per tooth (depending on materials used)
Complete upper or lower denture	$210 per denture
Immediate upper or lower denture	$235 per denture
Upper or lower partial denture	$202-$240 per denture (depending on materials used)

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.

What You Need to Know About Prior Authorization of Services

Prior authorization is the process of notification and approval for certain types of health care services, treatments or equipment by Health Plan of Nevada. This step is necessary to ensure benefit payment. Please consult your Plan documents for detailed information about the health care services, treatments and equipment requiring prior authorization. Except in cases of medical emergency, your provider or a representative from a licensed medical facility may submit a request for prior authorization by contacting Member Services. All prior authorization requests requiring a medical or clinical decision are reviewed by a licensed physician or under the supervision of one. Furthermore, only a physician may deny a request. Our Medical Director reviews each request on a case-by-case basis, taking into consideration special circumstances. If your request is denied or you have questions regarding a prior authorization, you may call Member Services. To initiate an appeal of a prior authorization decision, call Member Services or write to:

Customer Response and Resolution
Health Plan of Nevada, Inc.
P. O. Box 15645
Las Vegas, NV 89114-5645

Making Sure Inpatient Care is Appropriate, Timely and Necessary

If you ever receive care in an inpatient setting, such as a hospital, Health Plan of Nevada will monitor your care by performing initial and ongoing reviews. This is to make sure the medical services you receive are appropriate, provided in the right setting, and medically necessary. Reviews are conducted by our case managers either on-site at the hospital, or by telephone with one of the facility's nurses or your attending physician.

Planning for When You Leave the Hospital

Should you be hospitalized, discharge planning will begin within 24 hours of your admission. We will arrange for any ongoing care, services and equipment you may need after leaving the hospital. Depending on your situation, these plans could include transfer to another facility, such as a rehabilitation hospital. Or, you may be discharged to your own home to continue treatment on an outpatient basis.

Evaluating Care You Received

If you are admitted to a non-contracted facility or receive care or services outside of the Health Plan of Nevada service area, we may perform a retrospective review to evaluate the appropriateness of the medical care, services, treatments, and procedures you received. As part of this process, we will review your medical records, admitting diagnosis, and presenting symptoms.

SINCE 1982

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

☐ Direct Bill ☐ Sure Pay (AutoPay)

Please mark your selection.	☐ **Option 1 (HMO)**	☐ **Option 2 (HMO)**	☐ **Option 3 (POS)**	☐ **Option 4 (HMO)**	**Dental**:
	***12-month MWP	***No** Maternity Coverage	*12-month MWP	***No** Maternity Coverage	____ Yes ____ No Coverage applies to Southern Nevada **only**

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: (____)_____

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.**

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.

I hereby apply to HPN for coverage now being offered to my Eligible Family Member(s) and me, if any, as shown above. I understand that this application is subject to acceptance by HPN and that if an Agreement is issued, services will be available subject to the terms, exclusions, limitations and benefits described in the HPN Agreement of Coverage (AOC) and the applicable Attachment A, Benefit Schedule.

I hereby certify that me and my Eligible Family Member(s) are not eligible for Medicare and, (**Please check one box**), ☐ do not have other healthcare coverage; or ☐ have coverage with (Carrier):_____ which will be terminated when this Plan is made effective. If the other healthcare coverage is not terminated, or other healthcare coverage is obtained, then HPN shall have the right to term coverage retroactively to the original Effective Date and refund any corresponding premium.

If the application is declined or if the Member is not satisfied and within ten (10) days of actually receiving the AOC, the Applicant may request a full refund of the premium paid.

Conditions of Application:
It is important that you carefully read and fully understand the following: All Applicants age 18 and over must personally read, agree to, and sign below.

EFFECTIVE DATE
If HPN approves my application, please request an Effective Date of the: ☐ 1st of (month) _____ ☐ 15th of (month) _____
The Effective Date must be after the signature date, but not greater than forty-five (45) days from the signature date on this Individual HMO Enrollment Application.

The requested Effective Date is subject to change. If your Individual HMO Enrollment Application is approved for issue, your Effective Date will be communicated to you by HPN's Underwriting department via a confirmation of coverage letter. I understand that once the Individual HMO Enrollment Application is approved and the policy issued, HPN cannot change the established Effective Date.

Note: If you are adding an Eligible Family Member, the Effective Date will always be the first (1st) day of the calendar month following the month when the Individual HMO Plan Change Request Form is received and approved by HPN.

Applicant/GuardianSignature:_____ **Date:**_____

Spouse Signature:_____ **Date:**_____

Eligible Family Member's Signature (18 yrs and over)_____ **Date:**_____

Eligible Family Member's Signature (18 yrs and over)_____ **Date:**_____

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an HMO or 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 HMO or insurance company or agent of an HMO or 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 HMO or insurance proceeds shall be reported to the Division of Insurance.

INITIAL PAYMENT ONLY – OPTIONAL CREDIT CARD PREMIUM PAYMENT

You may choose to make your initial premium payment by check, money order or credit card. Credit card payment is available for your first premium payment only. All subsequent payments will be made through monthly bills. If choosing to pay by credit card, you must complete all of the following information:

☐VISA ☐Master Card ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐-☐☐☐☐ $_____

Credit Card # Exp Date: (mm/yyyy) Max Premium Amount Authorized

I authorize HPN to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	Cardholder Signature:	Date

AGENT INFORMATION

Tax ID #_____ Phone #: _____ Agency:_____ Agent:_____

Street Address: _____ City/State/Zip:_____ Agent's Signature_____ Date:_____

SINCE 1982

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

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	Name Last	First	MI	Sex	Date of Birth mo/day/yr	Height	Weight	Birthplace City State	Current Physician Name	Address
Self				☐ M ☐ F						
Spouse				☐ M ☐ F						
Child				☐ M ☐ F						
Child				☐ M ☐ F						
Child				☐ M ☐ F						
Child				☐ M ☐ F						
Child				☐ M ☐ 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)

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

16. Has anyone applying for healthcare coverage had treatment in the past five (5) years, contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing healthcare services? ☐ Yes ☐ No

17. Has anyone applying for healthcare coverage had cosmetic/reconstructive surgery? ☐ Yes ☐ No
If yes, please describe: _____

18. Has anyone applying for healthcare coverage received a prescription medication from any practitioner during the past twenty-four (24) months? ☐ Yes ☐ No

19. Has anyone applying for healthcare coverage been advised to undergo further testing, treatment or surgery including surgery performed by a dentist or oral surgeon? ☐ Yes ☐ No

20. Has anyone applying for healthcare coverage seen or consulted any doctor or any other person providing healthcare services for any other condition not listed elsewhere on this application? ☐ Yes ☐ No

21. Has anyone applying for healthcare coverage been declined, postponed, waiver applied, or charged an extra premium for life or health insurance, or had such insurance rescinded? ☐ Yes ☐ No
If yes, please provide name of proposed applicant, company name and brief explanation: _____

22. Is anyone applying for healthcare coverage on this application eligible for Medicare? ☐ Yes ☐ No

IMPORTANT:

23. If you answered **"**YES**"** to any questions above (PART II #1-22), please provide question number and explain in FULL DETAIL below. Use additional sheet, if necessary.

Question #	Family Member Name	Symptom/ Condition/ Diagnosis	Date of Onset	Date Recovered or Date last treated	Medication and date last taken	Physician's Name, Phone, Fax & Address

MEDICATIONS:

24. List all medications taken currently or within the past two (2) years by any family member listed on this application. Use additional sheet, if necessary.

Family Member Name	Medication/ Dosage/ Frequency	Illness for which Medication was Prescribed	Date Medication Started	Date Medication Completed	Still on this Medication	Physician's Name, Phone, Fax and Address
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ 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

SINCE 1982

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

_____ _____
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.

SINCE 1982

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

PRE-ARRANGED PAYMENTS AUTHORIZATION AGREEMENT

Applicant's Name:	Name of Bank Account holder(s):
Applicant's Social Security Number:	SS# of Bank 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:
Routing/Transit Number:	
Account Number:	Type of account: ☐ Checking ☐ 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 billed premium and/or any past due premiums** for my Individual Plan from HPN.

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 fifteen (15) days of the issuance of the account statement or forty-five (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.

Instructions:

1. Please provide a **pre-printed voided check** from the account in which premiums are to be withdrawn in order to facilitate the set-up of the electronic check (ACH) agreement.
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

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.

SINCE 1982

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.

Sierra Health and Life
Individual PPO Plans

Online. Anytime.
We're@YourService℠
www.sierrahealthandlife.com

Member Services

(702) 242-7700 or **(800) 888-2264**

Confidentiality of Member Information

Sierra Health and Life is careful to protect your privacy by developing operational policies and procedures for the way we work with other companies. Currently, Sierra Health and Life instructs all employees on confidentiality procedures.

We share protected health information (PHI) only with individuals or entities as necessary to coordinate your health care or administer your health benefits. When you enroll in one of our plans, we may use your PHI for future, known or routine purposes, such as treatment or conducting quality assessments. And, of course, we share PHI in accordance with state and federal law.

Sierra Health and Life uses security precautions to protect PHI or data about you containing personal facts and health information that is personally identifiable, either implicitly or explicitly. We also require our contracted providers to take similar steps to protect your PHI. Sierra Health and Life does not share your PHI, unrelated to plan administration, with employers unless we have your authorization.

We use medical data to promote and improve the quality of care you receive. When conducting research and measuring quality, Sierra Health and Life uses summary information whenever possible, not PHI. When we do use PHI, steps are taken to help protect it from inappropriate disclosure. We do not allow PHI to be used for research by organizations outside Sierra Health and Life without your consent.

You have the right to access your medical records and can do so by contacting your provider of care. When you request specific medical records be shared with others, Sierra Health and Life may require you to sign an authorization form. We may also ask you for special consent for non-routine uses of your personal data. Of course when we ask you for authorization to release your PHI, you have the right to refuse. In addition to authorizing us to release your PHI, this extra step helps you understand why your PHI will be shared. When a member/insured lacks the ability to authorize a release, we obtain authorization from persons recognized by state or federal laws to give such authorization.

Choose Sierra Health and Life

Our Individual PPO (IPPO) plans are designed to give you freedom of choice. Take a look at the Sierra Health and Life *Benefits at a Glance* section of this brochure. This snapshot provides you with the copayments, coinsurance and calendar year deductibles for the services most people refer to when making health care decisions. To find out more about how our plans work, review all the material we've presented to you. We are confident that you'll find an IPPO plan that is right for you and your family!

Prescription Drug Benefit

If you select a health plan with Sierra Health and Life, you'll have access to a wide range of effective and affordable medications. Please refer to the enclosed prescription drug plan summary for specific information about the plan available to you.

Select Quality Providers

Plan Provider Benefits

With our IPPO plans, you have the freedom to choose between two benefit levels: plan provider and non-plan provider. When utilizing plan provider benefits, you'll select providers from the Sierra Health and Life PPO Provider Directory and enjoy affordable, predictable copayments for routine services. These routine services, which include non-specialist and specialist visits, do not have calendar year deductibles or require filing claim forms. This benefit level offers lower cost-sharing for you while providing a higher level of coverage.

Non-Plan Provider Benefits

For those individuals who want the freedom to select any licensed provider, Sierra Health and Life IPPO plans include benefits for non-plan provider services. When using this benefit level, you'll share in more of the cost by paying a calendar year deductible and higher coinsurance for all covered services.

Sierra Health and Life *Benefits at a Glance*

Distinct Advantage Plans	PPO Plan 1 maternity coverage excluded		PPO Plan 2 maternity coverage excluded		PPO Plan 3 maternity coverage excluded	
	Plan Provider	Non-Plan Provider	Plan Provider	Non-Plan Provider	Plan Provider	Non-Plan Provider
Lifetime Maximum Benefit	$2,000,000 of EME*		$2,000,000 of EME		$2,000,000 of EME	
Calendar Year Deductible (CYD)	$1,000 per Insured; $2,000 per Family		$1,500 per Insured; $3,000 per Family		$2,500 per Insured; $5,000 per Family	
Annual Coinsurance Maximum (after CYD)	$1,000 per Insured $2,000 per Family	$2,000 per Insured $4,000 per Family	$1,500 per Insured $3,000 per Family	$3,000 per Insured $6,000 per Family	$2,500 per Insured $5,000 per Family	$5,000 per Insured $10,000 per Family
Physician Services Office Visit Consultation Preventive Care	$35 per visit $35 per visit $35 per visit	After CYD, you pay 50% of EME and all charges in excess of EME	$35 per visit $35 per visit $35 per visit	After CYD, you pay 40% of EME and all charges in excess of EME	$40 per visit $40 per visit $40 per visit	After CYD, you pay 30% of EME and all charges in excess of EME
Diagnostic Services Routine Laboratory Routine X-ray	After CYD, you pay 20% of EME	After CYD, you pay 50% of EME and all charges in excess of EME	After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess of EME	After CYD, you pay 10% of EME	After CYD, you pay 30% of EME and all charges in excess of EME
Hospitalization Inpatient Outpatient	After CYD, you pay 20% of EME	After CYD, you pay 50% of EME and all charges in excess of EME	After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess of EME	After CYD, you pay 10% of EME	After CYD, you pay 30% of EME and all charges in excess of EME
Physician Surgical Services Inpatient Hospital Outpatient Facility Anesthesia Physician's Office	After CYD, you pay 20% of EME $35 per visit	After CYD, you pay 50% of EME and all charges in excess of EME	After CYD, you pay 20% of EME $35 per visit	After CYD, you pay 40% of EME and all charges in excess of EME	After CYD, you pay 10% of EME $40 per visit	After CYD, you pay 30% of EME and all charges in excess of EME
Emergency Services Emergency Room Physician Services Ground Ambulance (when medically necessary) Urgent Care	After CYD, you pay 20% of EME $50 per visit	After CYD, you pay 50% of EME and all charges in excess of EME	After CYD, you pay 20% of EME $50 per visit	After CYD, you pay 40% of EME and all charges in excess of EME	After CYD, you pay 10% of EME $55 per visit	After CYD, you pay 30% of EME and all charges in excess of EME
Mental Health Services Outpatient Therapy (limited to 20 visits per Insured per Calendar Year)	After CYD, you pay 20% of EME	After CYD, you pay 50% of EME and all charges in excess of EME	After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess of EME	After CYD, you pay 10% of EME	After CYD, you pay 30% of EME and all charges in excess of EME

PPO Plan 4 maternity coverage excluded	
Plan Provider	Non-Plan Provider
$2,000,000 of EME	
$5,000 per Insured; $10,000 per Family	
$2,500 per Insured $5,000 per Family	$5,000 per Insured $10,000 per Family
$50 per visit $50 per visit $50 per visit	After CYD, you pay 40% of EME and all charges in excess of EME
After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess of EME
After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess of EME
After CYD, you pay 20% of EME $50 per visit	After CYD, you pay 40% of EME and all charges in excess of EME
After CYD, you pay 20% of EME $65 per visit	After CYD, you pay 40% of EME and all charges in excess of EME
After CYD, you pay 20% of EME	After CYD, you pay 40% of EME and all charges in excess of EME

Form No. SHL-IndDAP-masBS-2005

These plans 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. The Insured is 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 Sierra Health and Life Individual PPO Agreement of Coverage, Attachment A Benefit Schedules and applicable Endorsements, Disclosure Summaries and Riders. Copies of these 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*	$35
Non-Preferred Generic or Brand Name Drug*	$55
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.

*If a Generic Covered Drug equivalent is available, member pays the $7 copay plus the difference between the EME of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Plan Pharmacy for each therapeutic supply.

Form No. SHL-IPPO-3TierSI0-2004

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

Area for SHL use only:

☐ Declined ☐ Accepted Effective Date: ___/___/____
Date Processed ___/__/_____
Underwriter: _____

Individual PPO Enrollment Application Form

Individual PPO Selections: (please mark your selection)

☐ Plan 1 1000(35) – 85	☐ Plan 2 1500(35) - 86	☐ Plan 3 2500(40) - 97	☐ Plan 4 5000(50) - 86	☐ Direct Bill	☐ Sure Pay

Marital Status: ___ Single ___ Divorced ___ Married ___ Widowed Date of Marriage: _____ /_____/_____

Applicant Name: _____

Social Security No. _____

Street Address:_____
Street Apt # City State/Zip

Billing Address: (If different than above)_____

Home Phone: (____)_____ Email Address: _____

Business Phone: (____)_____ Occupation:_____

Employer Name: _____

Employee Address:

_____
Street Apt # City State/Zip

Emergency Contact Name:_____

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.

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	M or F	Relationship to Applicant	Birthdate	SS#	E S D
				Applicant			

Sierra Health and Life Insurance Company, Inc., ("SHL") has the right to increase premiums under this Agreement after providing sixty (60) days notice to the Applicant. Any such increase will apply to all Insureds in the same class. In addition, an increase will be applied if an Insured 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.

I hereby apply to SHL for coverage now being offered to my Eligible Family Member(s) and me, if any, as shown above. I understand that this application is subject to acceptance by SHL and that if an Agreement is issued, services will be available subject to the terms, exclusions, limitations and benefits described in the SHL Agreement of Coverage ("AOC") and the applicable Attachment A, Benefit Schedule.

I hereby certify that me and my Eligible Family Member(s) are not eligible for Medicare and, (**Please check one box**), ☐ do not have other healthcare coverage; or ☐ have coverage with (Carrier):_____ which will be terminated when this Plan is made effective. If the other healthcare coverage is not terminated, or other healthcare coverage is obtained, then SHL shall have the right to term coverage retroactively to the original Effective Date and refund any corresponding premium.

If the application is declined or if the Insured is not satisfied and within ten (10) days of actually receiving the AOC, the Applicant may request a full refund of the premium paid.

Conditions of Application:
It is important that you carefully read and fully understand the following: All Applicants age 18 and over must personally read, agree to, and sign below.

EFFECTIVE DATE
If SHL approves my application, please request an Effective Date of the:

☐ 1st of _____ (month) | ☐ 15th of _____ (month)

The Effective Date must be after the signature date, but not greater than forty-five (45) days from the signature date on this Individual PPO Enrollment Application.

The requested Effective Date is subject to change. If your Individual PPO Enrollment Application is approved for issue, your Effective Date will be communicated to you by SHL's Underwriting department via a confirmation of coverage letter. I understand that once the Individual PPO Enrollment Application is approved and the policy issued, SHL cannot change the established Effective Date.
Note: If you are adding an Eligible Family Member, the Effective Date will always be the first (1st) day of the calendar month following the month when the Individual PPO Plan Change Request Form is received and approved by SHL.

Applicant/Guardian Signature:_____ **Date:**_____

Spouse Signature:_____ **Date:**_____

Eligible Family Member's Signature (18 yrs and over)_____ **Date:**_____

Eligible Family Member's Signature (18 yrs 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.

INITIAL PAYMENT ONLY – OPTIONAL CREDIT CARD PREMIUM PAYMENT

You may choose to make your initial premium payment by check, money order or credit card. Credit card payment is available for your first premium payment only. All subsequent payments will be made through monthly bills. If choosing to pay by credit card, you must complete all of the following information:

☐VISA ☐Master Card

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐-☐☐☐☐ $_____

Credit Card # Exp Date: (mm/yyyy) Max Premium Amount Authorized

I authorize SHL to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	Cardholder Signature:	Date

AGENT INFORMATION Tax ID #_____ Phone #: _____ Date:_____

Agency:_____ Agent:_____

Street Address: _____ City/State/Zip:_____ Date _____

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

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 SHL for further instructions regarding your application for coverage.

Applicant Information

Applicant Number	Name Last	First	MI	Sex	Date of Birth mo/day/yr	Height	Weight	Birthplace City State	Current Physician Name Address
Self				☐ M ☐ F					
Spouse				☐ M ☐ F					
Child				☐ M ☐ F					
Child				☐ M ☐ F					
Child				☐ M ☐ F					
Child				☐ M ☐ F					
Child				☐ M ☐ 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 SHL'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)

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

16. Has anyone applying for healthcare coverage had treatment in the past five (5) years, contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing healthcare services? ☐ Yes ☐ No

INDIVIDUAL MEDICAL QUESTIONNAIRE

17. Has anyone applying for healthcare coverage had cosmetic/reconstructive surgery? ☐ Yes ☐ No
    If yes, please describe: _____

18. Has anyone applying for healthcare coverage received a prescription medication from any practitioner during the past twenty-four (24) months? ☐ Yes ☐ No

19. Has anyone applying for healthcare coverage been advised to undergo further testing, treatment or surgery including surgery performed by a dentist or oral surgeon? ☐ Yes ☐ No

20. Has anyone applying for healthcare coverage seen or consulted any doctor or any other person providing healthcare services for any other condition not listed elsewhere on this application? ☐ Yes ☐ No

21. Has anyone applying for healthcare coverage been declined, postponed, waiver applied, or charged an extra premium for life or health insurance, or had such insurance rescinded? ☐ Yes ☐ No
    If yes, please provide name of proposed applicant, company name and brief explanation: _____

22. Is anyone applying for healthcare coverage on this application eligible for Medicare? ☐ Yes ☐ No

IMPORTANT:

23. If you answered **"**YES**"** to any questions above (PART II #1-22), please provide question number and explain in FULL DETAIL below. Use additional sheet, if necessary.

Question #	Family Member Name	Symptom/ Condition/ Diagnosis	Date of Onset	Date Recovered or Date last treated	Medication and date last taken	Physician's Name, Phone, Fax & Address

MEDICATIONS:

24. List all medications taken currently or within the past two (2) years by any family member listed on this application. Use additional sheet, if necessary.

Family Member Name	Medication/ Dosage/ Frequency	Illness for which Medication was Prescribed	Date Medication Started	Date Medication Completed	Still on this Medication	Physician's Name, Phone, Fax and Address
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

INDIVIDUAL MEDICAL QUESTIONNAIRE

By signing this document:

- I understand that Sierra Health and Life Insurance Company, Inc. (SHL) 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 SHL 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 SHL. 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

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

APPLICANT AUTHORIZATION FORM

Sierra Health and Life 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 Sierra Health and Life Insurance Company, 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 Sierra Health and Life Insurance Company, 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.

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

PRE-ARRANGED PAYMENTS AUTHORIZATION AGREEMENT

Applicant's Name:	Name of Bank Account holder(s):
Applicant's Social Security Number:	SS# of Bank 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:
Routing/Transit Number:	
Account Number:	Type of account: ☐ Checking ☐ Savings

As a convenience to me, I (we) authorize Sierra Health and Life Insurance Company, Inc. ("SHL") to initiate debit entries to the account listed above at the bank or credit union (institution) listed above **equal to the monthly billed premium and/or any past due premiums** for my Individual Plan from SHL.

This authorization is to remain in full force and effect until SHL and the institution have received written notification from me (or either of us) of its termination in such a manner as to afford SHL 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 fifteen (15) days of the issuance of the account statement or forty-five (45) days after posting, whichever occurs first. Should this right be exercised, I (we) will notify SHL prior to such action to make arrangements for continuation or termination of coverage.

Instructions:

1. Please provide a **pre-printed voided check** from the account in which premiums are to be withdrawn in order to facilitate the set-up of the electronic check (ACH) agreement.
2. After application has been successfully processed by SHL, 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

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.

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

INDIVIDUAL PPO ("IPPO") DEPENDENT CHILD FORM

IF YOU ARE APPLYING FOR COVERAGE FOR A DEPENDENT CHILD/CHILDREN ONLY, PLEASE COMPLETE 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 dependent(s) listed below under the IPPO Plan underwritten by Sierra Health and Life Insurance Company, 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.

Enroll with Health Plan of Nevada or Sierra Health and Life

It's easy. Simply follow the instructions below.

1. **Please detach and complete the Health Plan of Nevada or Sierra Health and Life Individual Enrollment Application, Individual Medical Questionnaire and Applicant Authorization Form provided in the enclosed booklet.** Make sure that all information provided is complete and accurate. Be sure to indicate which plan you wish to enroll in, and sign and date each form.

2. **Print clearly** using blue or black ink.

3. **Enclose a check** made payable to Health Plan of Nevada or Sierra Health and Life with the appropriate premium for the plan you select. You have the option of making a monthly payment directly to Health Plan of Nevada or Sierra Health and Life by having your monthly payment deducted from your checking account with the SurePay option. If you elect the SurePay option, complete and sign the enclosed authorization agreement for pre-arranged payments, and enclose a voided check. If you elect direct billing, you will be charged a $10 fee each month.

4. **Return the Individual Enrollment Application, Individual Medical Questionnaire, Applicant Authorization Form and your check** to Health Plan of Nevada or Sierra Health and Life in the enclosed, self-addressed envelope.

5. **Our Medical Underwriting Department** will contact you as part of the enrollment process. This telephone interview must be completed before coverage can be approved.

Once your application is approved, we will forward your Agreement of Coverage, membership card and other important information to you. You will also receive written confirmation of approval and the effective date of your coverage.

If for any reason you are not satisfied with the policy after examining it for 10 days, you may return the policy for a full refund.

If we are not able to approve your application, you will receive written notice of declination.

Most Common Causes For a Delay In Processing:

- Missing or incomplete personal information such as: weight, height, spouse's social security number, age and date of birth.
- Incomplete information such as mailing address, telephone numbers, etc.
- Incomplete answers. If the question does not apply to you, please reply with N/A. Do not leave any answers blank.
- The application is not signed by all listed dependents over age 18.
- No response to telephone interview.
- Oldest person is not listed as primary subscriber.
- Altered applications.

P.O. Box 15645

Las Vegas, Nevada 89114-5645

Online. Anytime.

We're@YourService℠

www.healthplanofnevada.com

www.sierrahealthandlife.com