

Open Enrollment Change Form

- To make a plan change, print the plan name in the “For Employer Use Only” box located in the upper right hand corner of the form.
- Complete Section 1 with your HPN Member ID# (or SS#), and your name.
- Complete Section 2 if you have a change in address or phone number.
- Complete Section 3 if you are terminating your health coverage.
- Complete Section 4 if you are adding or removing dependent coverage.
- Sign & date Section 5.

Once complete, fax the form to (702) 796-9624 prior to December 16, 2011.



Membership Change Form

FOR EMPLOYER USE ONLY:

SECTION 1: ALL INFORMATION IN THIS SECTION MUST BE COMPLETED BY SUBSCRIBER

CURRENT GROUP/SUBSCRIBER #	NEW GROUP NUMBER	MEMBER ID # (OPTIONAL SS#)	EFFECTIVE DATE OF CHANGE
LAST NAME		FIRST NAME	M.I.
<input type="checkbox"/> REINSTATEMENT DATE		DATE OF HIRE:	
<input type="checkbox"/> REINSTATEMENT REASON		PAYROLL DEPT. (if applicable)	
TYPE OF CHANGE (CHECK THOSE BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTIONS)			
<input type="checkbox"/> NAME (SECTION 2)		<input type="checkbox"/> PHYSICIAN CHANGE:	
<input type="checkbox"/> ADDRESS/PHONE (SECTION 2)		NEW PHYSICIAN'S NAME _____	
<input type="checkbox"/> CONTRACT TERMINATION (SECTION 3)		PREVIOUS PHYSICIAN'S NAME _____	
<input type="checkbox"/> ADDITION OF DEPENDENTS (SECTION 4)		<input type="checkbox"/> PHYSICIAN CHANGE – DEPENDENTS (SECTION 4)	
<input type="checkbox"/> REMOVAL OF DEPENDENTS (SECTION 4)		<input type="checkbox"/> NEW PHYSICIAN CODE: <input type="checkbox"/> NEW OB/GYN CODE: <input type="checkbox"/> NEW DENTIST CODE:	
<input type="checkbox"/> MEDICARE ELIGIBLE (SECTION 4) <input type="checkbox"/> A <input type="checkbox"/> B		<input type="checkbox"/> ORDER NEW CARD	

SECTION 2: PERSONAL INFORMATION

NEW NAME (PLEASE PROVIDE LEGAL DOCUMENTATION):

LAST:	FIRST:	M.I.
NEW ADDRESS/PHONE:		
STREET:	APT #	PHONE
CITY:	STATE:	ZIP CODE:

SECTION 3: CONTRACT TERMINATION

COMPLETION OF THIS SECTION WILL TERMINATE COVERAGE FOR SUBSCRIBER AND ALL DEPENDENTS. COVERAGE IS IN EFFECT THROUGH MIDNIGHT OF THE TERMINATION DATE.

TERMINATION DATE: _____

REASON FOR TERMINATION: TERMINATED EMPLOYMENT (INVOLUNTARY) MOVED FROM SERVICE AREA OTHER _____
 LEFT EMPLOYMENT (VOLUNTARY) DECEASED
 INELIGIBLE DISSATISFIED

MAY WE SEND YOU INFORMATION ABOUT CONVERSION TO INDIVIDUAL COVERAGE? YES NO

SECTION 4: ADDITION/REMOVAL OF DEPENDENTS/PHYSICIAN CHANGE

ADDITION OF DEPENDENTS REMOVAL OF DEPENDENTS PHYSICIAN CHANGE

NAME:	LAST NAME	FIRST NAME	MI	DOB	SEX		DEPENDENT SS #	*M.D.	*OB-GYN	*DENTAL	IF MEDICARE ELIGIBLE	OTHER INS. COVERAGE
					M	F						
SPOUSE											<input type="checkbox"/> "A" <input type="checkbox"/> "B"	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD											<input type="checkbox"/> "A" <input type="checkbox"/> "B"	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD											<input type="checkbox"/> "A" <input type="checkbox"/> "B"	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD											<input type="checkbox"/> "A" <input type="checkbox"/> "B"	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD											<input type="checkbox"/> "A" <input type="checkbox"/> "B"	<input type="checkbox"/> YES <input type="checkbox"/> NO

EXPLANATION FOR CHANGE - YOU MUST ATTACH LEGAL DOCUMENTATION:

NEWBORN DATE _____ ADOPTION DATE _____ DECEASED INELIGIBLE DIVORCE DISSATISFIED
 MARRIAGE DATE _____ REENROLLMENT REASON _____ EXCEEDS AGE LIMIT OTHER _____

* REFER TO PRIMARY CARE PHYSICIAN LIST. ENTER THE NUMBER FOUND NEXT TO THE PRIMARY CARE PHYSICIAN YOU HAVE CHOSEN. IF APPLICABLE, CHOOSE A DENTAL PROVIDER.

IMPORTANT: FEMALES, REGARDLESS OF AGE, MAY CHOOSE TWO (2) PRIMARY CARE PHYSICIANS: ONE FOR MEDICAL CARE AND ONE FOR OB-GYN SERVICES.

SECTION 5: SIGNATURES

I HEREBY APPLY FOR AMENDMENT OF MY APPLICATION. IT IS MUTUALLY AGREED AS FOLLOWS: THESE CHANGES SHALL NOT BECOME EFFECTIVE UNLESS AND UNTIL ACCEPTED. THIS APPLICATION FOR CHANGE IN COVERAGE WILL BECOME A PART OF MY ORIGINAL APPLICATION AND WILL BE SUBJECT TO THE TERMS AND AGREEMENTS IN EFFECT WITH HEALTH PLAN OF NEVADA, INC. AND/OR SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC, UNITED HEALTHCARE COMPANIES. I REALIZE THAT ANY MISREPRESENTATION OR OMISSION RELATING TO THIS CHANGE FORM MAY RESULT IN RESCISSION OF COVERAGE TO THE ORIGINAL EFFECTIVE DATE.

EMPLOYEE SIGNATURE:	DATE:
EMPLOYER NAME:	HPN STAFF SIGNATURE & DATE:
EMPLOYER SIGNATURE:	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 FOR 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.