Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

2024 Individual Change Form

For use with Off Exchange policies only. Contact Nevada Health Link for On Exchange policies.

Section 1: All information must be completed by subscriber

*** Required**

First Name *	Last Name *		M.I.
Member ID *	DOB	SSN	Requested Effective Date *

Type of change (check the boxes that apply and complete the appropriate sections)

- ☐ Personal Information (Section 2)
- ☐ Change Coverage (Section 3)
- ☐ Ancillary Coverage (Section 4)
- ☐ Dependents (Section 5) (circle one): Add - Remove
- ☐ Broker of Record Change (Section 6)
- ☐ Termination/Request for New Policy for Dependents (Section 7)
- ☐ Other (Explanation): _____
- ☐ Termination (Section 8)

Set your delivery preferences (choose one). Opt-in to receive information electronically, request paper documents or update your information. Visit **HealthPlanofNevada.com** or **SierraHealthandLife.com** and sign in. First-time users will be directed to create an account using their member ID.

☐ **(Initial).** I am electing to receive all future notices and/or documents from Health Plan of Nevada/Sierra Health and Life in electronic format.

☐ **(Initial).** I am declining to receive all future notices and/or documents from Health Plan of Nevada/Sierra Health and Life in electronic format.

Section 2: Personal Information

New Name (please attach legal documentation, i.e., Marriage License, Driver's License)

Current Name:	New Name:

New Address/Phone/Email

Street:	Apt #:	Phone:
City:	State:	ZIP:
Email Address:	Social Security #:	Valid Nevada Driver's License / ID Number:

Race (Please choose one option below)		**Ethnicity** (Please choose one option below)	**Preferred Spoken and Written Language** (Please choose one option below)
□ Two or More Races	□ Native Hawaiian or Other Pacific Islander	□ Hispanic/Latino	□ English
□ American Indian or Alaska Native	□ White	□ Not Hispanic/Latino	□ Non English
□ Asian	□ Declined	□ Declined	□ Declined
□ Black or African American	□ Other		
□ [Middle Eastern]			

Section 3: To Change Coverage ☐ Open Enrollment (11/1/23 to 1/15/24 only) ☐ First of month following 90 day wait

Health Plan of Nevada: MyHPN Solutions HMO		Sierra Health and Life: MySHL Solutions EPO	
Bronze HMO	☐ 1 ☐ 2	Bronze EPO	☐ 11 ☐ 12 ☐ 13 ☐ 14
Bronze HMO Plus	☐ 3 ☐ 4	Silver EPO	☐ 1 ☐ 2 ☐ 6 ☐ 7 ☐ 8 ☐ 9
		Gold EPO	☐ 7
Silver HMO	☐ 1.1 ☐ 3.1 ☐ 4	Bronze HSA EPO	☐ 3.1
Gold HMO	☐ 7	Catastrophic EPO	☐ (available under age 30)

Section 4: Ancillary Coverage[1]

Type of change (check the boxes that apply)

Dental:
- ☐ Add PPO Adult Dental (ages 19+)
- ☐ Add DHMO Dental (all covered members)
- ☐ Remove Dental

Adult Vision (ages 19+):
- ☐ Add Coverage
- ☐ Remove Coverage

Section 5: Addition/Removal of dependents (NOTE: Use additional sheet if necessary)

(check the box that applies) ☐ **Addition** of dependents (attach supporting QLE documentation) ☐ **Removal** of dependents

	Last Name	First Name	MI	DOB	Gender M	Gender F	SSN (age 5+)	Valid NV DL/ID # (age 19+)	Tobacco use[2] Y/N
Spouse									

Race (Please choose one option below)	Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
☐ Two or More Races ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ [Middle Eastern] ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Other	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined	☐ English ☐ Non English ☐ Declined

	Last Name	First Name	MI	DOB	Gender M	Gender F	SSN (age 5+)	Valid NV DL/ID # (age 19+)	Tobacco use[2] Y/N
Child									

Race (Please choose one option below)	Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
☐ Two or More Races ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ [Middle Eastern] ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Other	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined	☐ English ☐ Non English ☐ Declined

	Last Name	First Name	MI	DOB	Gender M	Gender F	SSN (age 5+)	Valid NV DL/ID # (age 19+)	Tobacco use[2] Y/N
Child									

Race (Please choose one option below)	Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
☐ Two or More Races ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ [Middle Eastern] ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Other	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined	☐ English ☐ Non English ☐ Declined

	Last Name	First Name	MI	DOB	Gender M	Gender F	SSN (age 5+)	Valid NV DL/ID # (age 19+)	Tobacco use[2] Y/N
Child									

Race (Please choose one option below)	Ethnicity (Please choose one option below)	Preferred Spoken and Written Language (Please choose one option below)
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Explanation For Change - You must attach documentation to add dependent(s).

☐ Newborn date ____________________ ☐ Adoption date _____________________ ☐ Marriage date __________________

☐ Date of Loss of coverage ___________ ☐ Other ____

Section 6: Broker of Record Change Request

New Agency: _____ Incumbent Agency: _____

Section 7: Termination/Request for New Policy for Dependents

I am requesting termination of my policy effective _____ date.

I request that my dependent(s) be established on their own policy effective _____ date.

I understand the following:

1. That my policy will be terminated and that my dependent(s) will have a new policy, with a new Member ID number on the first of the month following my termination. Any automatic EFT payments will stop.
2. The new policy will be for the same plan.
3. Once the new Member ID is established, my dependent(s) will need to set up new automatic EFT payments, if desired.

Section 8: Termination

Completion of this section will terminate coverage for subscriber and all dependents. **Coverage is in effect through midnight of the last day of the month in which the termination request is received.**

Requested Termination Date: _____ Reason For Termination: _____

Section 9: Signature (required)

NOTE: HPN/SHL reserves the right to establish a revised schedule of premium payments provided it gives the Subscriber 30 days notice prior to the Annual Open Enrollment as established by Federal Guidelines. Any such adjustment will apply to all member/insureds in the same class.

I hereby apply to HPN/SHL for a change in coverage now being offered to my eligible family member(s) and me. I understand this application is subject to acceptance by HPN/SHL and if an agreement is issued, services will be available subject to the terms, exclusions, limitations and benefits described in the agreement of coverage, Attachment A Benefit Schedule and any applicable endorsements, riders and attachments thereto.

Subscriber/guardian 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 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.

[1] One mid-year change from one dental product to another is allowed. Members who terminate dental and/or vision mid-year will not be allowed to re-elect until the following open enrollment period. Ancillary changes are effective on the first day of the month following receipt of completed change form.

[2] Within the past six months has used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)