

# ***HOW TO ENROLL BY MAIL***

**Simply read and carefully follow the instructions below.  
If you need assistance, call Hokanson Insurance at  
702-269-9902. We are here to help you.**

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## ***Enrollment Into Your New HPN Health Plan In A Few Easy Steps.....***

Step 1: Read all materials within your Enrollment Kit.

Step 2: Select the Plan that best fit's your needs and budget.

Rates are based on your age, number of family members, and the plan you choose.

Step 3: Complete the required forms:

- Individual Enrollment Application
- Applicant Authorization Form
- Individual Medical Questionnaire
- Authorization Agreement for the SurePay option
- Dependent Form for children 17 and under
- Include a voided check
- Oldest spouse must be the applicant

Required Application Fees:

- **Check for first month's premium, made payable to HPN**

**Step 4: Return your completed application to:**

**Hokanson Insurance  
800 N. Rainbow Blvd. Suite 208  
Las Vegas, NV 89107.**

**It must be sent to Hokanson Insurance for processing.**

**Do not give to any unauthorized agents.**

**Don't delay! You have a limited time to take advantage of the lowest rates in the Nevada. Any questions? Call Rick at 269-9902, I am here to assist you**

**If this offer does not meet you needs, please call so we can discuss your options.**

**Share this offer with a friend or business associates. Have them call:**

**Rick Hokanson at Hokanson Insurance 269-9902**

Area for HPN use only:

Declined  Accepted  Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date Processed \_\_\_\_/\_\_\_\_/\_\_\_\_ Underwriter \_\_\_\_\_

### Individual HMO Enrollment Application Form

Direct Bill       Sure Pay (AutoPay)

Please mark your selection.	<input type="checkbox"/> <b>Option 1 (HMO)</b> *12-month MWP	<input type="checkbox"/> <b>Option 2 (HMO)</b> *No Maternity Coverage	<input type="checkbox"/> <b>Option 3 (POS)</b> * 12-month MWP	<input type="checkbox"/> <b>Option 4 (HMO)</b> *No Maternity Coverage	<b>Dental:</b> ____ Yes    ____ No Optional for <b>all</b> Individual Plans	<b>Vision:</b> ____ Yes ____ No
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Marital Status: \_\_\_\_ Single    \_\_\_\_ Married    \_\_\_\_ Divorced    \_\_\_\_ Widowed    Date of Marriage: \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Street Address: \_\_\_\_\_  
 Street                                      Apt #                                      City                                      State/Zip                                      County

Billing Address: (If different than above) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Name/Address: \_\_\_\_\_  
 Name                                      Street                                      Apt #                                      City                                      State/Zip

Emergency Contact Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**HIPAA Plans:**  
 \_\_\_\_ Standard    \_\_\_\_ Basic

I have attached proof that I meet the following HIPAA eligibility requirements:

1. My HIPAA qualifying event occurred no more than sixty-three (63) days prior to the date of this application;
2. Most recent healthcare coverage was under a Group Plan;
3. Have a minimum aggregate period of eighteen (18) months of Creditable Coverage;
4. Exhausted COBRA or similar continuation of coverage, if applicable;
5. Not covered by other healthcare coverage;
6. Do not qualify for Medicare or Medicaid;
7. Did not have Group healthcare coverage terminated for fraud or non-payment of premiums.

PLEASE LIST YOURSELF AND ALL ELIGIBLE FAMILY MEMBERS APPLYING FOR COVERAGE. Only your spouse and Eligible Family Member(s) under the age of 24 may apply except that those children between the ages of 19 and 24 are not eligible as Dependents unless they are full-time students and unmarried. If your child does not qualify as an Eligible Family Member, he/she may apply for his/her own Individual healthcare coverage.

**THIS SECTION MUST BE COMPLETED**

Last Name	First Name	MI	Sex M or F	Relationship to Applicant	Birthdate	SS#	Primary Physician	OB/GYN (For Females)*	ESD#
				Applicant					

**\* SELECT A PHYSICIAN CODE FROM THE HPN PROVIDER DIRECTORY INCLUDED IN YOUR ENROLLMENT PACKAGE. FEMALES SHOULD ALSO SELECT AN OB/GYN PHYSICIAN.**

Health Plan of Nevada, Inc., ("HPN") has the right to increase premiums for this Agreement after providing sixty (60) days notice to the Applicant. Any such increase will apply to all Members in the same class. In addition, an increase will be applied if a Member has a birthday that results in an age reclassification on the rate charts. Applications are subject to medical underwriting which may result in an increase in premium or rejection of application unless the Applicant qualifies for a HIPAA policy according to Nevada state law.

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:  1<sup>st</sup> of (month) \_\_\_\_\_  15<sup>th</sup> 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 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 (1<sup>st</sup>) day of the calendar month following the month when the Individual HMO Plan Change Request Form is received and approved by HPN.

**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 #      Expiration Date: (mm/yyyy)      Maximum 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
<b>INTERNAL USE ONLY: DO NOT WRITE BELOW THIS LINE</b>		
IPAD Auto ID#	Subscriber #	Date Processed:
Processed By:		

**Applicant/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Spouse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Family Member's Signature (18 yrs and over)** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**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.

<b><u>AGENT INFORMATION</u></b>			
Tax ID # _____	Phone #: _____	Agency: _____	Agent: _____
Street Address: _____	City/State/Zip: _____	Agent's Signature _____	Date: _____





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

### PART I PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Do you currently have, or has anyone applying for coverage had prior healthcare coverage in the past twelve (12) months?  Yes  No

If yes, name of Member/Insured: \_\_\_\_\_

Name of HMO/Insurance Carrier: \_\_\_\_\_

a) Was coverage provided by an:  HMO  Group Policy  Individual Policy

b) Effective Date: \_\_\_/\_\_\_/\_\_\_ c) Termination Date: \_\_\_/\_\_\_/\_\_\_ Reason for Termination: \_\_\_\_\_

If the termination date of prior healthcare coverage is within sixty-three (63) days of the date the Individual Medical Questionnaire is signed, please attach the Certificate of Creditable Coverage. **(This is mandatory for persons applying for the HIPAA Standard or Basic Plans.)**

d) If this application is accepted, do you agree to discontinue your current coverage?  Yes  No

e) Are you or any Eligible Family Member currently enrolled on COBRA?  Yes  No

If yes, Termination Date: \_\_\_/\_\_\_/\_\_\_

2. Is either the applicant, spouse, or any female Eligible Family Member(s), whether or not listed on the application currently pregnant?  Yes  No

**Please note:** Coverage under HPN's Individual Plans cannot be issued if you, your spouse, or any female Eligible Family Member (including a dependent child) is now pregnant, unless the pregnant individual is considered HIPAA eligible (See Individual PPO Enrollment Application).

3. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on this application?  Yes  No

4. Has anyone applying for healthcare coverage smoked or used any form of a tobacco product within the past twelve (12) months including, but not limited to the following: cigarettes, pipe, cigar, snuff, or chewing tobacco?  Yes  No

If yes, who? \_\_\_\_\_

a) Pack(s) per day? \_\_\_\_\_ b) How many years? \_\_\_ c) When did he/she stop the tobacco product use? \_\_\_/\_\_\_/\_\_\_

5. Has anyone applying for healthcare coverage consumed alcoholic beverages in any form within the past five (5) years?  Yes  No

If yes, who? \_\_\_\_\_

Please indicate the number of drinks consumed: \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly

(1 drink = 12 oz beer; 4 oz wine; 2 oz liquor)

# INDIVIDUAL MEDICAL QUESTIONNAIRE

6. Within the past five (5) years, has anyone applying for coverage had treatment for, been arrested for, or used any drug which was not prescribed by a physician such as amphetamines or other stimulants, barbiturates or other depressants, cocaine, heroin or other narcotics, LSD or other hallucinogens, marijuana, hashish or tranquilizers?  Yes  No
7. Has anyone applying for coverage ever had his/her driver's license suspended or revoked for driving while intoxicated, or ever been convicted of a felony?  Yes  No

**PART II**      **HEALTH HISTORY OF YOU AND YOUR FAMILY**  
**(Include information on ALL Eligible Family Members you wish to cover.)**

Has any person listed on this application within the past five (5) years ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions, diseases or disorders?    **For each "YES" answer, details must be given in question #23.**  
**(All questions must be answered.)**

1. Heart/Circulatory System – aneurysm, arteriosclerosis, chest pain, coronary heart disease, elevated cholesterol, heart attack, heart murmur, high or low blood pressure, palpitations, pacemaker, phlebitis, stroke, transient ischemic attacks (TIA), varicose veins, or any other disease or disorder of the heart/circulatory system?  Yes  No
2. Lungs/Respiratory System – allergies, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), difficulty breathing, emphysema, hay fever, pleurisy, pneumonia, pneumothorax, pulmonary embolism, pulmonary tuberculosis, shortness of breath, sinusitis, or any other disease or disorder of the lungs/respiratory system?  Yes  No
3. Brain/Nervous System – Bell's palsy, cerebral palsy, dizziness, epilepsy (convulsions and seizures), fainting spells, mental retardation, migraine headaches, multiple sclerosis, narcolepsy, paralysis, Parkinson's disease, stroke, or any other disease or disorder of brain/circulatory system?  Yes  No  
If epileptic: date of last seizure \_\_\_\_\_
4. Digestive System – cirrhosis, colitis, diarrhea, diverticulitis, fatty liver, gallbladder disease, gastric bypass surgery, gastroesophageal reflux disease (GERD), gastritis, hemorrhoids, hepatitis, hiatal hernia, inflammatory bowel diseases (Crohn's disease, Ulcerative colitis), intestinal problems, pancreatitis, rectal problems, ulcers, or any other disease or disorder of the esophagus, stomach, intestines or liver?  Yes  No
5. Genitourinary System – albuminuria, amenorrhea, cervical dysplasia, cervicitis, cystitis, dysmenorrhea, endometriosis, fibroid tumor, hematuria, hysterectomy, kidney stone, menorrhagia, nephritis, renal failure, renal transplant, urinary incontinence, urinary tract infections, or any other disease or disorder of the urinary system?  Yes  No
6. Skeletal and Muscular System – arthritis, back sprain/strain, bursitis, carpal tunnel syndrome, collagen vascular diseases (connective tissue diseases), fractures, gout, hip disorders, knee disorders, osteoporosis, or any other injury, disease or disorder of the joints, muscles or bones?  Yes  No
7. Nervous and Mental Disorders – alzheimer's, anxiety, anorexia, attention deficit disorder, behavioral problems, bipolar, bulimia, chemical imbalance, depression, eating disorder, emotional problems, or any other nervous and mental disorders?  Yes  No
8. Endocrine/Metabolic System – AIDS or AIDS-Related Complex, anemia, adrenal disorders, diabetes, immune disorders, lupus, Raynaud's, thyroid or any other endocrine/metabolic disease or disorder?  Yes  No
9. Male Reproductive System – disorders of the penis and scrotum, erectile dysfunction, genital herpes, genital warts, gonorrhea, impotency, infertility, prostate, urinary tract infections, sexually transmitted disease (STD), syphilis, or any other male genital disease or disorder?  Yes  No
10. Female Reproductive System – abnormal menstrual bleeding, abortion-miscarriage, breast disorder/cyst, endometriosis, fibroid tumors, genital herpes, genital warts, gonorrhea, infertility, menstruation disorders, ovarian cysts, pelvic pain, sexually transmitted disease (STD), syphilis, or any other female genital disease or disorder?  Yes  No
11. Has anyone applying for healthcare coverage been diagnosed with or treated for cancer, cyst, growth, leukemia, tumors (malignant or benign)?  Yes  No
12. Has anyone applying for healthcare coverage been diagnosed with or treated for cataract, glaucoma, or any other eye disease or disorder?  Yes  No
13. Has anyone applying for healthcare coverage been diagnosed with any physical deformity, birth defect, congenital problems or impairment?  Yes  No
14. Has anyone applying for healthcare coverage been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?  Yes  No
15. Has anyone applying for healthcare coverage been a patient of any hospital, clinic or other medical facility in the past five (5) years?  Yes  No

## INDIVIDUAL MEDICAL QUESTIONNAIRE

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 dYEsE 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
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> 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

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**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.**

**Applicant is acting as the personal representative for all dependents listed above.**

**OR**

**signers other than the applicant must present legal documentation that authorizes them to act on the applicant's behalf**



# HEALTH PLAN OF NEVADA, INC.<sup>SM</sup>

a subsidiary of Sierra Health Services, Inc.<sup>®</sup>

## AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS

Applicant's name:	Name of account holder(s):	
Applicant's social security number:	SS# of other account holder (s):	
Street address:		
City:	State:	Zip:
Telephone number - home:	Telephone number - business:	
E-mail Address - home:	E-mail Address - business:	
Bank name:	Bank branch:	
Bank address:		
Account number:	Type of account: <input type="checkbox"/> checking <input type="checkbox"/> savings	

As a convenience to me, I (we) authorize Health Plan of Nevada, Inc. (HPN) to initiate debit entries to the account listed above at the bank or credit union (institution) listed above **equal to the monthly premium** for The Personal Choice Plan from Health Plan of Nevada, Inc.

**This authorization is to remain in full force and effect until HPN and the institution have received written notification from me (or either of us) of its termination in such a manner as to afford HPN and the institution a reasonable opportunity to act on it.** I (or either of us) have the right to stop payment of a debit entry by notification to the institution prior to charging the account.

After the account has been charged, I (we) have the right to have the amount of an erroneous debit immediately credited to my (our) account by the institution, provided I (we) send written notice of the error to the institution within 15 days of the issuance of the account statement or 45 days after posting, whichever occurs first. Should this right be exercised, I (we) will notify HPN prior to such action to make arrangements for continuation or termination of coverage.

*Please note:*

1. Your application will not be processed without a **pre-printed voided check** from which monthly premiums are to be withdrawn.
2. After application has been successfully processed by HPN, a confirmation letter will be sent to you.
3. In the event your monthly premiums increase, (at renewal or due to a change in age bracket), the increased premium rate will be deducted from your account.

**X**

**X**

Signature of depositor(s) as appears on bank records

Date

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

## INDIVIDUAL DISTINCT ADVANTAGE – HMO DEPENDENT CHILD FORM

**IF YOU ARE APPLYING FOR COVERAGE FOR AN ELIGIBLE DEPENDENT CHILD/CHILDREN ONLY, PLEASE COMPLETE THE INFORMATION REQUESTED BELOW.**

I, \_\_\_\_\_, agree to be responsible for the payment of all premiums/refunds due in connection with coverage provided on behalf of the eligible dependent child/children listed below under the Distinct Advantage Plan underwritten by Health Plan of Nevada, Inc.

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

\_\_\_\_\_  
Signature of Parent or Court Appointed Legal Guardian

\_\_\_\_\_  
Date

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