

# SHL PPO Submission Checklist

1. **1<sup>st</sup> month premium must be included to be processed**  
Equal to 1<sup>st</sup> months premium in either check, money order made payable to SHL or Credit Card Payment + \$10.00 if you would like to be billed direct
  
2. **Enrollment Application Form**  
All information completed  
Requested Effective Date (1<sup>st</sup> or the 15<sup>th</sup> of each month)  
Signed and dated by Applicant (older spouse must be the applicant)
  
3. **Medical Questionnaire**  
All questions must be answered  
Verification phone number included  
Signed and dated by application ( and spouse if applicable )
  
4. **Application Authorization Form** completed by primary applicant
  
5. **Authorization for PreArranged Payments**  
Payments will be withdrawn automatically from a checking or savings account monthly beginning with the second month of coverage.  
All information completed, signed and dated
  
6. **Void Check** – If authorizing payments to be drafted from account
  
7. **Dependent Child Form** –  
Required for individual policy for child only under age 17
  
8. **Mail all Completed Applications to:**  
**Hokanson Insurance**  
**800 N. Rainbow Blvd Ste 208**  
**Las Vegas NV 89107**  
Completed applications must be received by the Sierra Health & Life Insurance Co 7 days PRIOR to requested effective date (1<sup>st</sup> or the 15<sup>th</sup> effective dates). Please indicate requested effective date on the Enrollment Application Form. If no requested effective date is requested, the 1<sup>st</sup> of the following month will be used. **Once received, Medical Underwriting will call to complete a Telephone Verification Interview within approximately 7 days of receipt of application.**

**If you have any questions, please contact your broker:**

**Rick Hokanson**

**PH: 702-269-9902**

**email: [smarthealth@cox.net](mailto:smarthealth@cox.net)**

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

Area for SHL use only:	
<input type="checkbox"/> Declined <input type="checkbox"/> Accepted	Effective Date: ___/___/___
Date Processed ___/___/___	
Underwriter: _____	

**Individual PPO Enrollment Application Form**

Individual PPO Selections: (please mark your selection)				<input type="checkbox"/> <b>Direct Bill</b>	<input type="checkbox"/> <b>Sure Pay</b>
<input type="checkbox"/> <b>Plan 1</b> 1000(35) - 85	<input type="checkbox"/> <b>Plan 2</b> 1500(35) - 86	<input type="checkbox"/> <b>Plan 3</b> 2500(40) - 97	<input type="checkbox"/> <b>Plan 4</b> 5000(50) - 86	<b>Dental:</b> ___ Yes ___ No	<b>Vision:</b> ___ Yes ___ No
Marital Status: ___ Single ___ Divorced ___ Married ___ Widowed				Date of Marriage: ___/___/___	
Applicant Name: _____				<b>I qualify for a HIPAA Plan:</b> ___ 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.	
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/Address: _____ Name Street Apt # City State/Zip					
Emergency Contact Name: _____					
Phone Number: (____) _____					

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	DOB	SS#	E S D
				<b>Applicant</b>			

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.





## 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	Last	Name First	MI	Sex	Date of Birth mo/day/yr	Height	Weight	Birthplace City State	Current Physician Name Address
Self				<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					
Child				<input type="checkbox"/> M <input type="checkbox"/> F					

### 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)

# INDIVIDUAL MEDICAL QUESTIONNAIRE

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

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

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

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



# INDIVIDUAL MEDICAL QUESTIONNAIRE

By signing this document:

- I understand that 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  
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**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

\_\_\_\_\_ Relationship to applicant  
Printed name of applicant's representative

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.®**  
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**AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS**

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: <input type="checkbox"/> Checking <input type="checkbox"/> 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 premium** for my IPPO 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.

**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 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.



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INSURANCE COMPANY, INC.<sup>®</sup>**  
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**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:** \_\_\_\_\_

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