



FOR SALES USE ONLY:	
SIEBEL POLICY	_____
EFFECTIVE DATE	_____
INDIVIDUAL REP	_____

2019 Individual Change Form

Section 1: All information must be completed by subscriber

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)

- | | |
|---|--|
| <input type="checkbox"/> Personal Information (Section 2) | <input type="checkbox"/> Add/Remove Dependents (Section 5) |
| <input type="checkbox"/> Change Coverage (Section 3) | <input type="checkbox"/> Termination (Section 6) |
| <input type="checkbox"/> Ancillary Coverage (Section 4) | <input type="checkbox"/> Other (Explanation): _____ |

Set your delivery preferences (choose one). Opt-in to receive information electronically, request paper documents or update your information. Visit myHPNonline.com or mySHLonline.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:	Name Changes:
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New Address/Phone/Email

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

Section 3: To Change Coverage Open Enrollment (11/1 to 12/15 only) 90 day wait

Health Plan of Nevada: MyHPN Solutions HMO		Sierra Health and Life: MySHL Solutions EPO	
Bronze HMO	<input type="checkbox"/> 7 <input type="checkbox"/> 10 <input type="checkbox"/> 13	Bronze EPO	<input type="checkbox"/> 9
Silver HMO	<input type="checkbox"/> 1.1 <input type="checkbox"/> 3.1	Silver EPO	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 6
		Gold EPO	<input type="checkbox"/> 7
Gold HMO	<input type="checkbox"/> 7	Bronze HSA EPO	<input type="checkbox"/> 3.1
		Catastrophic EPO	<input type="checkbox"/> 1

Section 4: Ancillary Coverage²

Type of change (check the boxes that apply)

Dental:

- Add PPO Dental Remove Dental
- Add DHMO Dental

Vision:

- Add Coverage
- Remove Coverage

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

Addition of dependents Removal of dependents

	Last Name	First Name	MI	DOB	Gender		Dependent SSN (age 5+) Valid NV DL/ID # (age 19+)	Tobacco use ¹ Y/N	Other Ins. Coverage
					M	F			
Spouse									<input type="checkbox"/> Yes <input type="checkbox"/> No
Child									<input type="checkbox"/> Yes <input type="checkbox"/> No
Child									<input type="checkbox"/> Yes <input type="checkbox"/> No
Child									<input type="checkbox"/> Yes <input type="checkbox"/> No

Explanation For Change - You must attach documentation to add dependent(s) if other than a 90 day wait.

- Newborn date _____
 Adoption date _____
 Other _____
 Marriage date _____
 Loss of coverage _____

Section 6: 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 7: Signature (required)

NOTE: HPN/SHL has the right to adjust premiums for this agreement after providing sixty (60) day notice to the applicant. 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 that this application is subject to acceptance by HPN/SHL and that 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 Within the past six months has used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)

² Mid-year changes from one dental product to the other are not allowed. Members who terminate dental and/or vision mid-year will not be allowed to re-elect until the following open enrollment period.