Open Enrollment Form – Instructions

- To switch health plans, enter the plan name (PPO or HMO) in the box on the upper right hand corner where it says "For Employer Use Only."

- Section 1 – Enter your name and HPN member ID number (or your social security number).

- Section 2 – Enter any name change, address change, or phone number change (if necessary).

- Section 3 – Complete this section if you are terminating all health benefits with the School Administrators' and Professional-Technical Employees' Welfare Trust.

- Section 4 – Complete this section if you are adding or removing dependents from your health insurance (name, date of birth, sex, and social security number are required).

- Section 5 – Sign and date the form next to "Employee Signature."

If you are adding dependents to your health coverage, the following documentation will be required:

Spouse Addition – a copy of your marriage certificate

Domestic Partner Addition - a copy of the Nevada Domestic Partnership filing, and the completed Declaration of Domestic Partnership form

Child Addition – a copy of the birth certificate

Once completed, either scan & email all paperwork to nick.venturini@ccasa.net, or fax the paperwork to 1-702-447-6886 (you must dial the 1-702).

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

P.O. BOX 15645
LAS VEGAS, NV 89114-5645

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
10001851			8/1/17

LAST NAME	FIRST NAME	M.I.

☐ REINSTATEMENT DATE	DATE OF HIRE:
☐ REINSTATEMENT REASON	PAYROLL DEPT. (if applicable)

TYPE OF CHANGE (CHECK THOSE BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTIONS)

- ☐ **NAME** (SECTION 2)
- ☐ **ADDRESS/PHONE** (SECTION 2)
- ☐ **CONTRACT TERMINATION** (SECTION 3)
- ☐ **ADDITION OF DEPENDENTS** (SECTION 4)
- ☐ **REMOVAL OF DEPENDENTS** (SECTION 4)
- ☐ **MEDICARE ELIGIBLE** (SECTION 4) ☐ A ☐ B
- ☐ **PHYSICIAN CHANGE**:
  - NEW PHYSICIAN'S NAME _____
  - PREVIOUS PHYSICIAN'S NAME _____
- ☐ **PHYSICIAN CHANGE – DEPENDENTS** (SECTION 4)
- ☐ **NEW PHYSICIAN CODE:** ☐ **NEW OB/GYN CODE:** ☐ **NEW DENTIST CODE:**
- ☐ **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 M	SEX F	DEPENDENT SS #	*M.D.	*OB-GYN	*DENTAL	IF MEDICARE ELIGIBLE	OTHER INS. COVERAGE
SPOUSE											☐ "A" ☐ "B"	☐ YES ☐ NO
CHILD											☐ "A" ☐ "B"	☐ YES ☐ NO
CHILD											☐ "A" ☐ "B"	☐ YES ☐ NO
CHILD											☐ "A" ☐ "B"	☐ YES ☐ NO
CHILD											☐ "A" ☐ "B"	☐ YES ☐ 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 Open Enrollment

* 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.