Health Plan of Nevada A UnitedHealthcare Company



2025 Individual Change FormFor use with Off Exchange policies only. Contact Nevada Health Link for On Exchange policies.

Section 1: All information must be completed by subscriber * Required								* Required		
First Name * Last Name		Last Name *				M.I.				
Member ID *		DOB		SSN		Requested E	ffective Date *			
Type of change	Type of change (check the boxes that apply and complete the appropriate sections)									
□ Personal Information (Section 2) □ Tobacco Attestation (Section 6) □ Termination/Request for N □ Change Coverage (Section 3) □ Broker of Record Change (Section 7) □ for Dependents (Section 8 □ Termination (Section 9) □ Dependents (Section 5) □ Other (Explanation): □ Other					-					
Email Address for paperless communications: By providing your email address, you agree, 1) to be automatically enrolled in paperless delivery for some of your plan communications, and 2) you have reviewed the Required Plan Communications Notice ³ . You also agree to receive Required Plan Communications electronically. You will get many of your required plan communications delivered electronically. We will send you an email when new communications (such as: benefit and plan information, claims, billing and payments, regulatory notices and tax documents) are available online. If you would rather have hard copies of required materials mailed to you, please check here: Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time by signing in to the online member center.										
Section 2: Pe	rsonal Information									
**	New Name (please attach legal documentation, i.e., Marriage License, Driver's License)									
Current Name:			Ne	New Name:						
New Address/Phone/Email										
Street:			Apt#: Phon				1e:			
City:			State: ZIP:							
Email Address: Soc			al Se	curity #:	Driver's Licen	se / ID Number:				
Race (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			(Ple	nicity ease choose one option be lispanic/Latino lot Hispanic/Latino eclined		glish				
Section 3: To Change Coverage □ Open Enrollment (11/1/24 to 1/15/25 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			□13 □1			
Bronze HMO			Silver EPO C			□ 6 □ 7	□8 □9			
Plus				Gold EPO						
	Silver HMO			Bronze HSA EPO 3.1			,			
Gold HMO	□ 7			Catastrophic EPO			(available ı	under age 30)		

	Continue 4. Outlined Augillant Coverence (A. 1.1%)										
Section 4: Optional Ancillary Coverage¹ (additional premium applies) (must be enrolled in an off exchange medical plan in order to add ancillary dental and/or vision)											
Type of change (check the boxes that apply)											
Dental: ☐ Add PPO Adult Dental (ages 19+)			пР	□ Remove Dental				Adult Vision (ages 19+): Add Coverage			
☐ Add PFO Addit Dental (ages 191) ☐ Add DHMO Dental (all covered members)			<u> </u>	Remove Dental			□ Remove Coverage				
Section	n 5: Addition/Removal	of dependents (N	OTE: l	Jse addition	al she	et if n	ecessa	ıry)			
(check the box that applies)											
	First Name	Last Name	МІ	DOB	DOB Gender S		SSN	Valid NV DL/ID # (age 19+)		Tobacco use ² Y/N	
Spouse											
Race	phoose one ention helpw)	1		Ethnicity	oco ono	ontion	holow)		Spoken and Writt		
						(Please choose one option below)					
□ American Indian or Alaska Native Islander				□ Not Hispar		10		□ Non English			
□ Asian□ Black (White Declined		□ Declined				□ Decline	ed		
□ Middle	Eastern	Other									
ICHRA (I	ndividual Coverage Health Reim	bursement Arrangement)	: Yes	□ No □ U	nknowr	1					
QSEHRA	QSEHRA (Qualified Small Employer Health Reimbursement Arrangement): QSEHRA (Qualified Small Employer Health Reimbursement Arrangement Arrangemen										
	eck applicable boxes	0	SEHRA	Medical/Rx Cl	aims						
	<u>A Plan Premium</u> riber QSEHRA used for Plan Pre	mium	Subscri	ber QSEHRA	used fo				reimbursement		
□ Spous	al QSEHRA used For Plan Prem	ium	•	al QSEHRA use ber and Spous						ursement	
□ Not Applicable □ Unknown □ Subscriber and Spousal QSEHRA used for medical and/or Rx claim reimbursement □ Not Applicable □ Unknown											
			Νοι Αρμ	olicable \Box	Unkno	wn					
	First Name	Last Name	MI	DOB DOB	Gen		SSN (age 5+)	Valid NV DL/ID #	Tobacco	
Child	First Name						SSN (age 5+)	Valid NV DL/ID # (age 19+)	Tobacco use² Y/N	
Race	First Name choose one option below)			DOB Ethnicity	Gen M	der F		Preferred		use² Y/N	
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Section 6: Tobacco Attestation					
If you originally enrolled as a tobacco user and have been tobacco free for at least six months, check here. If you originally enrolled as a non-tobacco user and have recently started using tobacco products, check here. Upon submission of this attestation, your premium will be adjusted to reflect the tobacco or non-tobacco rate effective the first day of the following month in which we receive this completed change form.					
Section 7: Broker of Record Change Request					
New Agency:	Incumbent Agency:				
Section 8: Termination/Request for N	ew Policy for Dependents				
I am requesting termination of my policy effective date. Any automatic EFT payments will stop. 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. 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 9: Termination					
Section 10: 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)
- ³ Certain laws require that we give specific information to you in writing. We may send Required Plan Communications electronically when you give us permission. Not all Communications require permission before sending. This Notice only applies when permission is required. You may change your mind at any time, and we will send paper communications to you. These Communications may include: Plan documents and legal notices; Benefit decisions, such as Explanation of Benefits; and Privacy notices. Communications are based on the Plan you have. You will get new communications as they become electronic. If there is not an electronic version, we will send by mail.

How will Communications be sent? We will send you an email when a document is ready to view online.

What if my email changes? Update your email right away. It is your responsibility to give us correct information. Communications may be delayed if we have the wrong information. If this happens, you hold us harmless.

What happens if I change plans? If you change or add a benefit plan, program, product or service, we may use the same contact information you provided before.

Can I go back to mail? Yes, you may change your mind at any time. You may change your choice by going to your member website or mobile application or call the member number on your ID card. Paperless delivery will stay until you change your choice to mail. Changes may take up to seven business days to process.

Can I get a paper copy? Yes, you have the right to a free paper copy. You may print a copy on your member website or call the member number on your ID card and we will mail it to you.

Hardware and software requirements In order to get, view, and keep these Communications you must have, at your own cost, the following: Internet or Mobile access; Registration on member website; An email account with software; and Acrobat Reader or similar software to view PDF files.

^aWe means United HealthCare Services, Inc. and/or Optum, Inc. and/or their affiliated companies