

LABOR ENROLLMENT FORM



HMO benefits are underwritten by Health Plan of Nevada, Inc. Indemnity benefits are underwritten by Sierra Health and Life Insurance Company, Inc.

PLEASE TYPE OR PRINT NEATLY IN BLACK/BLUE INK. ALL NON-SHADED FIELDS MUST BE COMPLETED.

Employer Name		Name: Last	First	M.I.	Social Security No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Effective Date
Date of Birth / /	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Mailing Address: Street Apt. No. City State Zip			Home Phone ()		Group No.
Occupation/Title		Date of Hire* Full-Time / /	Employer I.D. No. (if applicable)	Work Phone ()	Annual Salary	Have you previously been a Member of HPN? <input type="checkbox"/> Yes <input type="checkbox"/> No	Coverage
HPN Primary Care Provider Code**	I am enrolling in the following coverage (if offered by my employer) from HPN/SHL .*** HPN: <input type="checkbox"/> HMO Medical <input type="checkbox"/> POS Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision SHL: <input type="checkbox"/> Life <input type="checkbox"/> Dental <input type="checkbox"/> Vision		I am enrolling my Eligible Family Member(s) in the following coverage (if offered by my employer) from HPN/SHL .*** HPN: <input type="checkbox"/> HMO Medical <input type="checkbox"/> POS Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision SHL: <input type="checkbox"/> Life <input type="checkbox"/> Dental <input type="checkbox"/> Vision		If Medicare Eligible (check) <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Who should we contact in case of emergency? Name: Daytime/business phone number:	Class Code
HPN OB/GYN Provider Code**		Personal e-mail address:		Number of hours worked per week?	Do you receive a paycheck? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often?	Supplemental Life
*If the employee is reclassified to full-time status, please provide the date of full-time employment. **Refer to Primary Care Provider Directory. Enter the number found next to the Provider you choose as a Primary Care Provider. Important: Females may choose two (2) HPN Primary Care Providers; one (1) Physician for medical care and one (1) for OB/GYN. *** If declining any coverage offered you, you must complete a Waiver Form for that coverage.							COBRA <input type="checkbox"/> Yes <input type="checkbox"/> No
							Effective Date:

ELIGIBLE FAMILY MEMBER(S) INFORMATION (Complete only if Dependent coverage is desired)

Relation to Applicant	Last Name	First	MI	DOB Mo/Day/Yr	Sex M/F	Social Security Number	Full-Time Student Status	HPN Primary Care Provider Code**	HPN OB/GYN Provider Code**
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	--	--
Child							<input type="checkbox"/> Yes <input type="checkbox"/> No	--	--

IMPORTANT: THIS SECTION MUST BE COMPLETED

<p>1. Are you or any of your Eligible Family Member(s) covered by a Health Benefit Plan, Medicare or Medicaid now or in the past eighteen 18 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" is checked, please complete the following: A.) Carrier's name: _____ B.) Effective date: _____ C.) Termination date: _____ D.) Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life E.) <input type="checkbox"/> Active employee <input type="checkbox"/> Retirement benefits F.) <input type="checkbox"/> Single <input type="checkbox"/> Family If family, list names of Eligible Family Member(s) covered: _____</p> <p>2. Name of spouse and/or Eligible Family Member(s) who are currently employed: _____ A. Social Security No.: _____ B. Date of Birth: _____ C. Employer Name: _____ D. Employer's Telephone No.: _____</p>	<p align="center">SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.</p> <p>1. Life Insurance - Primary Beneficiary designation information (when offered by my employer): Name and Relationship: _____ _____ Address: Street _____ City _____ State _____ Zip _____</p> <p>2. Life Insurance - Contingent Beneficiary designation information (when offered by my employer): Name and Relationship: _____ _____</p> <p>3. Supplemental Life amount requested (if offered): \$ _____</p> <p>4. Was a Medical Questionnaire completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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I understand that my Authorized Representative or I am entitled to a copy of this form upon request. I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. I agree that they shall be used as the basis of acceptance for coverage of me and my Eligible Family Member(s) (if any). I acknowledge that I understand each of the questions asked in this form as well as the terms used in those questions. I realize that any material misrepresentation or omission regarding eligibility for coverage may result in rescission of my coverage. I accept as valid a photocopy of this authorization with my affixed signature.

Employee Signature (Signature for self and Eligible Family Member(s))

DATE

Authorized Signature/Employer (if required)

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.

WAIVER FORM

HMO and Indemnity benefits are underwritten by Health Plan of Nevada, Inc. Life, AD&D, and Dental benefits are underwritten by Sierra Health and Life Insurance Company, Inc. **Please Type or Print In Black Ball-Point.**

Refusal of Group Coverage(s)/Contributory Plan Only

Name: Last	First	M.I.
Employer		

Important notice: If you are declining enrollment for yourself or your Eligible Family Member(s) (including your spouse) because of other healthcare coverage, you may in the future be able to enroll yourself or your Eligible Family Member(s) in this Plan provided that you request enrollment within thirty-one (31) days after your other coverage ends, **or** within thirty-one (31) days after a marriage, birth, adoption or Placement for Adoption.

This is to certify that I have been given the opportunity to apply for Group coverage(s) available to me and/or my Eligible Family Member(s) pursuant to Nevada State law through the Employer listed above.

1. I waive the following coverage (where applicable) for myself:

Medical Coverage Dental Coverage Vision Coverage Life Insurance

2. I waive the following coverage (where applicable) for all of my Eligible Family Member(s):

Medical Coverage Dental Coverage Vision Coverage Life Insurance

3. I made this decision to waive all coverage offered by the Employer listed above because:

Coverage is already provided by another Health Benefit Plan. **If this box is checked, please attach a copy of the Member's Identification Card(s) or complete the following information:**

A. Carrier Name: _____

B. Group Health Benefit Plan **or** Individual Health Benefit Plan

C. Carrier Phone Number: (_____) _____

D. Effective Date: _____

E. Policy Number: _____

F. Amount of Contributions paid by Current Employer \$ _____

G. Member ID or Social Security Number(s): _____

H. Benefits Provided: Medical/Rx Dental
 Vision Life

I have no other coverage and choose to waive this coverage because I do not want and/or cannot afford this coverage.

I have been given an opportunity to participate in the Group Health Benefit Plan provided by Health Plan of Nevada, Inc. and offered by my employer. I understand that if I choose to apply for this healthcare coverage at a later date, I will have to wait until my next Plan Open Enrollment Period unless I am currently enrolled in another Health Benefit Plan and a Special Enrollment Event occurs.

Date _____ Employee Signature _____
(Signature for self and Eligible Family Member(s))

Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to a healthcare company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any healthcare company or agent or a healthcare 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.