nevada health co-op
simply better

NEVADA HEALTH CO-OP GROUP ENROLLMENT

Employee: To receive your ID card, please CLEARLY complete all non-shaded areas and sign Section D. Shaded Areas To Be Completed by Employer

Date of Hire (mm/dd/yy): / /	**Client Group Number:**
Requested Effective Date or Date of Change: / /	**Client Group Name:**

Reason for Application

□ Open Enrollment □ New Hire □ Rehire □ New Group Plan □ Change Name/Address
□ Dependent Add □ Dependent Term □ Special Enroll Event Date_____________ □ Other _____________

Termination □ Voluntary □ Involuntary
□ COBRA or State Continuation
Start Date ____/____/____ End date ____/____/____

Employer Verification Signature : **Date:**

Waiver of Coverage (This section must be completed and signed if declining medical coverage)

I decline coverage for:	I am declining coverage due to existing coverage:	
□ Myself □ Spouse / DP □ Dependent Children □ Myself and all eligible family members	□ Spouse's Employer Plan □ Medicare □ Individual □ Medicaid □ Cobra from prior employer □ Tri-Care □ VA Eligibility □ Other _____________	I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a Special Enrollment Event or at the next Open Enrollment Period. Employee Signature Date

A. Employee Information.

Last Name	First Name	MI	Social Security Number - -	Home Phone ( ) Cell Phone ( )
Address	Apt #	City	State	Zip Code
Date of Birth (mm/dd/yy)	Sex □ M □ F	Date of Hire (mm/dd/yy)	Plan Choice	

Marital Status: □ Single □ Married □ Domestic Partner (DP) □ Divorced □ Widowed □ Separated

Primary Language □ English □ Spanish □ Other ______________________

ALL documents and correspondence will be available in our CO-OP website at *www.nevadahealthcoop.org*

Tobacco User □ Yes □ No

Email Address:

Would you like to receive correspondence via postal mail? □Yes □ No

B. Eligible Family Member(s) Information (Complete only if Dependent coverage is desired. Attach additional sheet, if necessary).

Relationship (if relationship is different than the options listed, please write the relationship)				Sex	Plan Choice	Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)?
Spouse or DP	Last Name	First Name	MI	□ M □ F		□ Yes □ No
	Birthdate	Social Security #				
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No
	Birthdate	Social Security #				

B. Eligible Family Member(s) Information (Continuation. Attach additional sheet, if necessary).

Relationship (if relationship is different than the options listed, please write the relationship)				Sex	Plan Choice	Within the past six months have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial use)?
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No
	Birthdate	Social Security #				
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No
	Birthdate	Social Security #				
Child	Last Name	First Name	MI	□ M □ F		□ Yes □ No
	Birthdate	Social Security #				

C. Other Medical Coverage Information (This Section must be completed. Attach sheet if necessary.)

Are you eligible for Medicare? □ Yes □ No

* ***A**. Enter "A" if this dependent is covered by **A**nother individual (not a member of your household) required to pay for this dependent's medical expenses.*
***B**. Enter "B" if this dependent is covered under **B**oth you and your spouse's insurance plan (married).*
***S**. Enter "S" if you are the **S**ole parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.*

Other Group Medical Coverage Information: (only list those covered by other plan)

Main Policyholders Name	Name and date of birth of members with other coverage	Type (A, B or S)*	Effective Date	End Date	Name of the Carrier

D. Signature (Form must be signed)

I (we) request the indicated group medical coverage for myself, and, if the plan provides, for my Eligible Family Members. I authorize any required premium contributions to be deducted from earnings. I (we) understand that NEVADA HEALTH CO-OP is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. 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 future claims being denied and the policy, or my coverage under the policy, being rescinded or reevaluated, as of the effective date. I am encouraged to maintain a copy of this authorization for my records.

I understand plan documents will determine the rights and responsibilities of members(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan. I understand and agree that providers and vendors are independent contractors in private practice and are neither employees nor agents of NEVADA HEALTH CO-OP.

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief.

Broker/Agency Code:	**Broker/Agency Name:**
Date:	**Subscriber/Applicant Signature (for self and Eligible Family Members)**

E. Arbitration of Dispute of an Independent Medical Review

If a Member is dissatisfied with the findings of an Independent Medical Review, the Member shall have the right to have the dispute submitted to *binding* arbitration before an arbiter under the commercial arbitration rules applied by the American Arbitration Association. By signing below ____ acknowledges notice of and consents to binding arbitration if (Applicant) is dissatisfied with the findings of an Independent Medical Review. (Print Applicant Name)

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 Nevada Division of Insurance.