nhc nevada health co-op simply better

NEVADA HEALTH CO-OP INDIVIDUAL ENROLLMENT

Subscriber: To receive your ID card, please CLEARLY complete all non-shaded areas and sign Section D.	**Requested Effective Date or Change:** ______/______/______

Reason for Application

☐ Open Enrollment ☐ Change Name/Address ☐ Dependent Add
☐ Dependent Term ☐ Special Enroll Event Date____________ ☐ Other ____________

Child only policy? ☐Yes ☐ No

A. Subscriber 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	Plan Choice	Premium Amount	

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

Primary Language ☐ English ☐ Spanish ☐ Other ____________

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

I am Currently a Nevada Resident ☐ Yes ☐ No

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/ 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 #				
Child	Last Name	First Name	MI	☐ M ☐ F		☐ Yes ☐ No
	Birthdate	Social Security #				
Child	Last Name	First Name	MI	☐ M ☐ F		☐ Yes ☐ No
	Social Security #	Birthdate				

B. Eligible Family Member(s) Information[4] (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 #				

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

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another Nevada Health Co-Op plan or Medicare? □ YES (continue completing this Section) □ NO (skip the rest of this Section)

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 medical coverage for myself, and, if the plan provides, for my Eligible Family Members. 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 Signature (for self and Eligible Family Members)**

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 subscriber or claimant for the purpose of defrauding or attempting to defraud the subscriber or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance.