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
Last Name	First Name	M.I.	Date of Hire
Contact Phone ( )	Work Phone ( )	Email	
☐ Reinstatement Date	☐ 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 or Removal of Dependents** (*Section 4*)
☐ **Medicare Eligible** (*Section 4*) ☐ **A** ☐ **B**

☐ **Physician Change** ☐ **Physician Change – Dependents** (*Section 4*)
New Physician's Name ______________________
Previous Physician's Name______________________
☐ **New Physician code** ☐ **New OB/GYN code**
☐ **New Dentist code** ☐ **Order New Card**

Section 2: Personal Information (*New Name: Please provide legal documentation*) ☐ **Change for Employee** ☐ **Change for Dependent**

Last	First	M.I.
Street Address	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: Additional/Removal of Dependents/Physician Change: ☐ **Addition of Dependents** ☐**Removal of Dependents** ☐ **Physician Change**

	Last Name	First Name	MI	DOB	Sex M	Sex F	Dependent SS#	*PCP	*OB/GYN	*Dental	Medicare Eligible	Other INS. Coverage
Spouse/ D. Partner											☐ A ☐ B	☐ Yes ☐ No
Child											☐ A ☐ B	☐ Yes ☐ No
Child											☐ A ☐ B	☐ Yes ☐ No
Child											☐ A ☐ B	☐ Yes ☐ No
Child											☐ A ☐ B	☐ Yes ☐ No

* 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.

Explanation for Change – You must attach legal documentation

☐ Newborn Date ____________________ ☐ Adoption Date ____________________
☐ Marriage Date ____________________ ☐ Reenrollment Reason ____________________

☐ Deceased ☐ Ineligible ☐ Divorced ☐ Dissatisfied
☐ Exceeds age limit ☐ D. Partner Registration
☐ Other ______________________________

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., UnitedHealthcare 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 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.