Print Form

OptimaHealth

❑ **Optima Health Plan** (Vantage, POS, Design HMO)
❑ **Optima Health Insurance Company** (Plus, Foursight, Equity, Design PPO)

FOR PLAN USE ONLY
Subscriber #:_____
Date:_____

Enrollment Application & Waiver Coordination of Benefits

IMPORTANT: Incomplete information will delay enrollment. ***Please complete all sections in blue or black ink.***

A. GROUP INFORMATION *(Required to be completed by Employer)*

❑ NEW Applicant ❑ ADD Dependent/Spouse ❑ Address Change ❑ Name Change
❑ CANCEL ALL ❑ Cancel Dependent/Spouse ❑ COBRA (effective date _____/_____/_____) ❑ PCP Change

Group Number	Group Name	Benefit Administrator Signature – Required	Subscriber Membership Number

Date Hired	Status	Association Code	Effective Date of Coverage (new hire waiting period must be satisfied)	Coverage Cancellation Date
_____/_____/_____	❑ Hourly ❑ Salaried		_____/_____/_____	_____/_____/_____

B. EMPLOYEE INFORMATION *(PLEASE PRINT LEGAL NAME)*

Last Name	First Name	Middle Initial	DOB	Email Address	Social Security No.
					– –

Home Address	City	State	Zip Code

Home Phone	Work Phone	Sex	Marital Status
		❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

My employer has given me an opportunity to apply for group health coverage with the plan for myself and my dependents (if applicable). I have declined to apply for coverage as indicated below. If electing coverage for self and all dependents, I may disregard section C.

Health Savings Account (HSA) Administration - *If you have chosen a HSA eligible high deductible plan offered through your employer, you are eligible to establish a Health Savings Account (HSA). HealthEquity is Optima Health's preferred vendor for HSA account administration. There is a nominal monthly administration fee with this account. Do you want to establish a HSA account?*

❑ *Yes, please* ***do*** *establish a health savings account for me with HealthEquity. Effective date* _____

❑ *No, please* ***do not*** *establish a health savings account for me with HealthEquity. Effective date* _____

C. WAIVER OF EMPLOYEE AND/OR DEPENDENT HEALTH COVERAGE

(Please check the one which applies.)

❑ I decline coverage for myself (and my dependents, if any).
❑ I decline coverage for my spouse only.
❑ I decline coverage for my children only.
❑ I decline coverage for my spouse and my children.

REASON FOR DECLINING *(MUST CHECK ONE)*

❑ Covered under another health coverage policy or CHAMPUS/TRICARE. (If this box is checked, below information is required)

Insurance Company Name: _____ Policy Holder's Name: _____

❑ Other Reason *(Answer Required)* _____

Signature: _____ **Date:** _____

D. ENROLLMENT INFORMATION

- If applying for Optima Health Plan Health Maintenance Organization or the Optima Health Plan Point of Service Plan, please select a primary care physician from the Plan's Provider Directory for each family member listed. The PPO and OOA Plans do not require primary care selection.
- If requesting coverage for a full-time student between the ages of 19 and 24, please provide proof of full-time status.

Last Name	First Name, Middle Initial	Social Security	Date of Birth Mo/Day/Year	Male/ Female	PCP & Address (For HMO or POS)	Current Patient
Employee: *Employee information will be taken from Section B above.*						❑ Yes ❑ No
Spouse ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No

E. OTHER COVERAGE INFORMATION (Required before enrollment can be completed.)

- Will anyone to be covered by this plan carry coverage in addition to this Plan?

❑ No If NO, skip to Section G ❑ Yes If YES, then please provide the following information about that coverage.

Insured Person (Name)	Identification (Policy) No.	Effective Date
Name of Insurance Company	If "Group" Coverage, Name of Employer or Organization Providing Coverage	

List Anyone Applying for Coverage Who Will Also Be Covered by This Insurance.

If Medicare Coverage:

Covered Person (Name)	HIC Number	Effective Date of Part A	Effective Date of Part B

Eligible Due to:	❑ Age	❑ Disability	❑ End Stage Renal Disease (ESRD) Mo Year	❑ Disability & Current ESRD Mo Year	65 or Over ❑ Working ❑ Retired
Eligible Due to:	❑ Age	❑ Disability	❑ End Stage Renal Disease (ESRD) Mo Year	❑ Disability & Current ESRD Mo Year	65 or Over ❑ Working ❑ Retired

F. CERTIFICATION AND AUTHORIZATION

I hereby certify that I have read or have had read to me, the completed application and realize that any false statement or misrepresentation in the application may result in loss of coverage under this policy.

I hereby authorize any physician, hospital, pharmacy, pharmacy benefit manager, or any other provider of health services or supplies, any insurance company or other organization, institution, or person that has any records or knowledge of my health or my dependents health, to give Sentara Health Plans, Inc. as agent for the insurer Optima Health Plan or Optima Health Insurance Company as checked on page 1 of the application, any such information for the purposes of compiling an accurate evaluation of this application, for administering Coordination of Benefits provisions, and for the payment of claims. This Authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record.

I understand that any information received by Optima Health pursuant to this application is subject to restrictions on disclosures to others as set forth under state and Federal laws. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand the authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment.

I understand that I or my authorized legal representative may receive a copy of this Authorization upon request and I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that for the purposes of collecting information about me and my dependents in connection with application for coverage, policy reinstatement, or a request for change in policy benefits that this Authorization is valid for thirty (30) months from the date shown. I understand that for the purposes of processing and payment of claims and for administration of coordination of benefits provisions this Authorization is valid for the term of the policy.

I certify that I am working at the employer's place of business in full-time employment at least twenty-five (25) hours per week. If I am accepted for coverage, I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and I understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on the Member ID card issued to me or my dependents. I understand that my employer's application will determine the coverage in force and that coverage is not in force if an application for the coverage has not been made by my employer. I am applying for health coverage for the persons listed on the application, and I agree that we shall abide by the provisions of coverage in the policy document under which we will be enrolled. I understand that it is my responsibility to report to Optima Health any change in eligibility of my self and my dependents. I certify that all dependents are legally my responsibility. I agree to provide proof of eligibility that is acceptable to Optima Health if requested. I understand that I will be responsible for payment of all required copayment, and/or coinsurance at the time services are provided.

I understand that I am obligated to select a Plan participating primary care physician for myself and for my covered dependents if applying for coverage under Optima Health Plan HMO or Point of Service plan. I further understand and certify that if my employer is offering coverage under an HMO health plan that I have been offered the option by my employer to enroll in an optional plan which permits myself and my eligible dependents to receive the full range of covered benefits from non-plan providers.

I understand that I can revoke this Authorization at any time by giving written notice to Optima Health at 4417 Corporation Lane, Virginia Beach, VA 23462. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the Authorization prior to receiving notice of my revocation. I have made and kept a copy of this application. I understand that if I am accepted for coverage this application will become part of my policy.

X

Employee Signature In Ink **Date**

Group Number	Group Name	Employee Health Questionnaire
Effective Date	Subscriber Membership Number	Subscriber Name

G. HEALTH QUESTIONS *(TO BE COMPLETED BY EMPLOYEE FOR EMPLOYEE AND ALL DEPENDENTS LISTED IN SECTIONS B & C)*

Within the past 5 years, have you, or any person on this application, had or been treated for the following diseases or impairments? Please check the appropriate box beside the condition and **provide details in SECTION I for any condition checked "yes":**

Yes	No		Yes	No		Yes	No	
❑	❑	Liver Disorder (Hepatitis/Cirrhosis)	❑	❑	Diabetes	❑	❑	Gall Bladder Trouble
❑	❑	Kidney/Bladder Problems	❑	❑	Stomach Ulcers	❑	❑	Tumors
❑	❑	Stomach/Intestinal Disorder	❑	❑	Arthritis	❑	❑	HIV
❑	❑	Disease/Disorder of Spine or Back	❑	❑	Alcohol or Drug Abuse	❑	❑	Tuberculosis
❑	❑	Cancer	❑	❑	Epilepsy	❑	❑	Brain Disorder
❑	❑	Sexually Transmitted Disease	❑	❑	Current Pregnancy (Due Date	❑	❑	Connective Tissue Disease (Lupus)
❑	❑	Asthma (Date of last attack			_____/_____/_____)	❑	❑	Allergies
		_____/_____/_____)	❑	❑	Acquired Immune Deficiency Syndrome (AIDS)	❑	❑	Sleep Apnea
❑	❑	Nervous/Mental or Psychological Disorder	❑	❑	Hemophilia	❑	❑	Cerebral Palsy
❑	❑	Multiple Sclerosis	❑	❑	Gout	❑	❑	Cystic Fibrosis
❑	❑	High Cholesterol	❑	❑	Heart Problems	❑	❑	Emphysema
❑	❑	High Blood Pressure	❑	❑	Thyroid Trouble	❑	❑	Respiratory Disorders

Additional Information About You and Your Dependents:

1. Employee: Height _____ ft. _____ in. Spouse: Height _____ ft. _____ in.

   Weight _____ lbs. Weight _____ lbs.

2. Within the past five (5) years, have you, or any person named on this application, consulted a physician or other provider for medical or surgical treatment or advice for any condition NOT listed in SECTION H?
   ❑ No ❑ Yes ***(If Yes, please provide details in SECTIONS I (a) and I (b).)***

3. Within the past five (5) years, have you, or any person named on this application, been advised to have an operation which has not been performed or to enter a treatment program not currently being received?
   ❑ No ❑ Yes ***(If Yes, please provide details in SECTIONS I (a) and I (b).)***

4. Within the past five (5) years, have you, or any person named on this application, been declined on a previous health insurance application?
   ❑ No ❑ Yes ***(If Yes, please provide details in SECTIONS I (a) and I (b).)***

H. (a) PRESCRIPTION MEDICATION HISTORY

Please provide information on any prescribed medication (including injections) that you or any of your listed dependents have used within the past 5 years. Please provide information on past and current prescription drug usage. If you need more space, please attach additional documentation to this application.

Individual's First Name	Medication	Dosage (amount and frequency)	Beginning date of use	Ending date of use

H. (b) MEDICAL TREATMENT HISTORY

If you checked "Yes" to any part of SECTION H, please provide complete information regarding diagnosis, conditions, or treatments – include all hospitalizations, surgery, and diagnostic testing. If you need more space, continue on reverse.

Individual's First Name	Diagnosis	Date Diagnosed	Attending Physician's Name and Address	Complete Recovery?

H. (b) MEDICAL TREATMENT HISTORY *CONTINUED*

If you checked "Yes" to any part of SECTION H, please provide complete information regarding diagnosis or condition; treatments – include all hospitalizations, surgery, and diagnostic testing. If you need more space, please attach additional documentation to this application.

Individual's First Name	Diagnosis	Date Diagnosed	Attending Physician's Name and Address	Complete Recovery?

I. MEDICAL PROFILE SUPPLEMENT CERTIFICATION

Please read and provide signature and date. Signature is REQUIRED for underwriting review.

The undersigned applicant certifies that he/she has read, or has had read to him/her, the completed application and realizes that any false statement or misrepresentation in the application may result in loss of coverage under this policy.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my health or my dependents or their health, to give Sentara Health Plans,Inc. as agent for the insurer, Optima Health Plan, or Optima Health Insurance Company as checked on page 1 of this application, any such information for the purposes of compiling an accurate evaluation of this application and for the payment of claims. Authorization to disclose information for the payment of claims is valid for the term of coverage. I do understand that I or my authorized representative may receive a copy of this application upon request. I agree that a photographic copy of this Authorization shall be as valid as the original and that for the purpose of collecting information in connection with application for coverage, policy reinstatement, or a request for change in policy benefits, this Authorization shall be valid for thirty (30) months from the date shown below. I understand that for the purpose of processing and payment of claims and for the administration of coordination of benefits provision, this authorization is valid for the term of the policy.

I certify that I am working at the employer's place of business in full-time employment at least twenty-five (25) hours per week. If I am accepted for coverage, I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and I understand that my employer is performing this service for my benefit and not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on each Member ID card issued to me. I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for the coverage has not been made by my employer.

I am applying for health coverage for the persons listed, and agree that we shall abide by the provisions of coverage in the coverage document under which we will be enrolled. I understand that it is my responsibility to report to the plan indicated on page one (1) any change in the eligibility of my dependents and that all dependents listed are legally my responsibility. If requested, documentation will be supplied. I understand that I am obligated to select a Plan-participating primary care physician for myself and for my covered dependents if choosing Optima Health Plan Health Maintenance Organization or Optima Health Plan Point of Service. I further understand that all services, except emergency services, must be authorized or provided by the primary care physician if choosing Optima Health Plan or Optima Health Plan Point of Service. I also understand that I am obligated to pay applicable copayments at the time services are rendered.

Employee Name *(Please Print)* | Company Name

X

Employee Signature In Ink | **Date** | Daytime Phone