

## For Broker Use Only

### Optima Individual and Family Health Plans

Brokers, there are two ways you can submit a completed paper application. The quickest way to submit a paper application is to enter it online from your broker portal. Or you can mail it in to your Optima representative. The choice is yours. We look forward to receiving your applications. To avoid delays with your applications, please review the following instructions to ensure your clients applications are submitted correctly.

#### **Submitting a Paper Application Online For Your Client**

1. You have a completed and signed application.
2. Enter Optima Health's broker portal
3. If you have not yet created a case for your client, go to your "General Tasks" bar and select, "Direct Apply for IFP" and skip to step 6.
4. If you've already created a case for this applicant, then go to the "Case Summary" for your client.
5. Choose "Start Application"
6. On the "Prior to Applying" screen, you will be prompted to select either HSA or traditional health plans. Select one and choose "continue"
7. The next screen you will be asked "Who will start the Application?" Choose, "I will enter the completed paper application for my client".
8. You will then be launched into the online application. At the end of it you will be asked if you have the paper application and signature on file. Click to confirm, then hit submit. Your application is now in underwriting.

#### **Mailing Your Client's Paper Application To Optima**

1. If you are working with a GA, you must send your completed application to your GA representative.
2. Optima will return all incomplete applications.
3. Please allow 3 to 5 business days before you will be able to view your case online via the broker portal
4. Applications received more than 15 days after date signed will not be accepted.

#### **Underwriting Updates**

- Whether you enter your application online or mail it in, you will be responsible for checking your broker portal for updates.
- Through your broker portal you can communicate directly with underwriting or your Optima representative.

#### **Approval Procedure**

1. Upon approval, sales will email out an "Approval Notice" to the broker with the approved rates.
2. Please note, the approval notice is just an offer and does not mean there is an issued policy yet.
3. Underwriting will issue the policy as soon as the signed "Approval Notice" is sent back to underwriting.
4. It will be the broker's responsibility to send the notice to their client.

***For your records, please keep a copy of these instructions and a copy of the application.***

## **Important Items to Know:**

### **1. Premium Payment**

- Initial Payment
  - Credit Card - **Visa** or **MasterCard** only.
  - Personal Check/Money Order/Cashiers Check – Accepted only if mailing in application
- Subsequent Payments - Must be set-up as an automatic draft or debit from a checking account and will be drafted between the 5<sup>th</sup> and 7<sup>th</sup> of each month.
- The first payment will not be drafted until your application has been approved and the offer accepted.
- All payment information is required to complete the application.

### **2. Medical Review**

- Monthly premiums are based on a confidential medical review of an applicant's medical history.
- This review may take anywhere from 3 to 30 days, with the average being 8 business days.
- If additional information is required, the applicant will be contacted by Optima Health, or its representative through phone or e-mail.
- Optima Health may request medical records and/or require a limited medical exam for anyone applying for coverage. A Nurse Practitioner will contact applicants to set-up the exam. All medical records requests and medical exams will be at Optima Health's expense.
- Anyone applying for coverage may be declined based on the overall medical review. Optima Health will notify applicants of their rights, if coverage is declined.

### **3. Effective Date of Coverage**

- Effective dates of coverage begin on either the 1<sup>st</sup> or the 15<sup>th</sup> of the month, based on when your application is received.
- The earliest effective date available is determined by the date the application is received. If received between the 1<sup>st</sup> and the 15<sup>th</sup> of the month, the earliest effective date is the 1<sup>st</sup> of the following month. If received between the 16<sup>th</sup> and the 31<sup>st</sup> of the month, the earliest effective date is the 15<sup>th</sup> of the following month.

### **4. Maternity Rider**

- This coverage is not yet available.

### **5. Health Savings Accounts (HSAs)**

- If your client is applying for one of the Optima Equity plans, they are eligible for an HSA account.
- Optima Health's preferred HSA administrator is HealthEquity, but your client may choose any HSA administrator.
- If HealthEquity is selected, there are no start up or monthly administration fees.
- If client chooses Health Equity, Optima will automatically set up a HealthEquity account. HealthEquity will then send a start up kit within 10 days after policy issue.

# Optima Health Individual and Family Health Plans

## Broker Submittal Form

Brokers, before you mail in your application, please complete the submittal form with each application. Failure to do so may cause delays in processing. Incomplete applications will be returned.

Agent Name \_\_\_\_\_ Email \_\_\_\_\_  
Agency/Agent Number \_\_\_\_\_ Phone \_\_\_\_\_

Applicant's Name \_\_\_\_\_  
Requested Effective Date \_\_\_\_\_ (1<sup>st</sup> or the 15<sup>th</sup> only – please refer to eff date rules)  
Plan Name \_\_\_\_\_

Initial Payment (will not be processed until offer is accepted)

Check/Cashiers Check/Money Order (must be attached) Amount \_\_\_\_\_  
(If issued amount is different than amount submitted, then adjustment will be made on 1<sup>st</sup> monthly draft)  
or

Credit Card (Visa or Mastercard)

Ongoing Payments – Must be completed. (monthly draft out of checking/savings only)

Health Questions Completed

- Details for all 'yes' answers
- Treatment dates, type of treatment, current status, Dr's name
- Medication, reason, dosage and dates

Applicant Signature's – Each applicant over the age of 18 must sign.

Agent's Signature

Copy for Agent

### Where to send applications

- If you are working with a GA, you must send all applications to your GA representative.
- If you are working directly with Optima Health, please mail your applications to :

Optima Health  
4417 Corporation Lane  
Virginia Beach, VA 23462  
Attn: Individual Sales

Thank You for Your Business



4417 Corporation Lane  
Virginia Beach, VA 23462

Optima Health Insurance Company  
Individual Product  
Enrollment Application

## INDIVIDUAL HEALTH INSURANCE APPLICATION

### APPLICANT INFORMATION

*Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.*

I am applying for: (Circle One)

- a. New coverage
- b. I am an existing policy holder applying for a policy change
- c. I am an existing policy holder applying to add dependent(s) to my current policy
- d. I am a former member of Optima Health

### Applicant Demographic

*Is this a child-only application? If applying for child-only coverage, please enter the youngest child as the primary applicant and all additional children, if any, on the Family Members page.*

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address Line 1: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Address Line 2: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ Ext.: \_\_\_\_\_

City: \_\_\_\_\_ Email: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Occupation: \_\_\_\_\_

SSN: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Pounds

### Guardian Information

Name of Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

### Mailing Address

Same Address as above?

Address Line 1: \_\_\_\_\_ City: \_\_\_\_\_

Address Line 2: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

### Coverage Information

Request Effective Date: \_\_\_\_\_

If available, please enter the applicable direct mail promotional code.

**FAMILY MEMBERS**

*Complete the following information for each of your family members.*

**Family Member Applying for Coverage**

**Family Member #1**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Pounds

Is this an adoption/guardianship?  Yes  No Occupation: \_\_\_\_\_

Does this family member live at the same address as the applicant?  Yes  No

No (If no, please provide address of dependent):

\_\_\_\_\_  
\_\_\_\_\_

Is the dependent a full time student?

Yes (If yes, please provide the following information):

Name of College/University: \_\_\_\_\_

Semester Attending: \_\_\_\_\_

Credit Hours: \_\_\_\_\_

Are you applying for coverage for a dependent who is disabled and incapable of self sustaining support or employment due to disability from mental or physical handicap?  Yes  No

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**Family Member #2**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Pounds

Is this an adoption/guardianship?  Yes  No Occupation: \_\_\_\_\_

Does this family member live at the same address as the applicant?  Yes  No

No (If no, please provide address of dependent):

\_\_\_\_\_  
\_\_\_\_\_

Is the dependent a full time student?

Yes (If yes, please provide the following information):

Name of College/University: \_\_\_\_\_

Semester Attending: \_\_\_\_\_

Credit Hours: \_\_\_\_\_

Are you applying for coverage for a dependent who is disabled and incapable of self sustaining support or employment due to disability from mental or physical handicap?  Yes  No

**Family Member #3**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Pounds

Is this an adoption/guardianship?  Yes  No Occupation: \_\_\_\_\_

Does this family member live at the same address as the applicant?  Yes  No

No (If no, please provide address of dependent):

\_\_\_\_\_  
\_\_\_\_\_

Is the dependent a full time student?

Yes (If yes, please provide the following information):

Name of College/University: \_\_\_\_\_

Semester Attending: \_\_\_\_\_

Credit Hours: \_\_\_\_\_

Are you applying for coverage for a dependent who is disabled and incapable of self sustaining support or employment due to disability from mental or physical handicap?  Yes  No

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**Family Member #4**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Pounds

Is this an adoption/guardianship?  Yes  No Occupation: \_\_\_\_\_

Does this family member live at the same address as the applicant?  Yes  No

No (If no, please provide address of dependent):

\_\_\_\_\_  
\_\_\_\_\_

Is the dependent a full time student?

Yes (If yes, please provide the following information):

Name of College/University: \_\_\_\_\_

Semester Attending: \_\_\_\_\_

Credit Hours: \_\_\_\_\_

Are you applying for coverage for a dependent who is disabled and incapable of self sustaining support or employment due to disability from mental or physical handicap?  Yes  No

**MEDICAL COVERAGE SELECTION**

Plan Name: \_\_\_\_\_

Maternity Rider?  Yes  No

Name of person needing coverage: \_\_\_\_\_

Well Child Care Rider?  Yes  No

Name of person needing rider?: \_\_\_\_\_

Morbid Obesity Rider?  Yes  No

Name of person needing coverage?: \_\_\_\_\_

**Health Savings Account (HSA) Administration** - If you have chosen a HSA eligible high deductible plan you are eligible to establish a Health Savings Account (HSA). HealthEquity is Optima Health Insurance Company's preferred vendor for HSA account administration. An account will automatically be set up for you with HealthEquity, unless you decline this option (please select "No" to decline). An account administration fee is included in your premium amount, regardless of whether you choose to use this preferred vendor. As with most other HSA vendors a nominal fee will be charged if you later choose to terminate the account once it has been established.

Please **establish** a HSA account for me with HealthEquity Yes \_\_\_\_ No \_\_\_\_

**PRIOR COVERAGE**

**Previous Optima Members**

Are any applicants existing or former Optima Members?  Yes  No

If yes, please provide the applicant's prior subscriber/member number and termination date below:

<u>Name</u>	<u>Subscriber/Member ID</u>	<u>Termination Date, if applicable</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Prior Carrier Information**

Did any applicant have medical coverage within the last 12 months?  Yes  No

If yes, please provide details below:

**Coverage Applies To:**

**Name:** \_\_\_\_\_

Type of Coverage: \_\_\_\_\_ Carrier Name: \_\_\_\_\_

Start Date of Coverage: \_\_\_\_\_ End Date of Coverage: \_\_\_\_\_

**Name:** \_\_\_\_\_

Type of Coverage: \_\_\_\_\_ Carrier Name: \_\_\_\_\_

Start Date of Coverage: \_\_\_\_\_ End Date of Coverage: \_\_\_\_\_

**Name:** \_\_\_\_\_

Type of Coverage: \_\_\_\_\_ Carrier Name: \_\_\_\_\_

Start Date of Coverage: \_\_\_\_\_ End Date of Coverage: \_\_\_\_\_

*Please place additional information on a separate page and attach if necessary.*

## APPLYING AS AN HIPAA ELIGIBLE INDIVIDUAL

Under a federal act known as HIPAA (Health Insurance Portability and Accountability act) there are protections in place to help individuals maintain health coverage when they lose or change jobs. *If you qualify as an Eligible Individual insurers in the individual market may not refuse to offer you coverage.*

*To qualify as an Eligible Individual all of the following must be true:*

1. You must have had at least 18 months of prior creditable coverage without a break of more than 63 days without any coverage or without being in a waiting period for coverage\*; **AND**
2. Your most recent coverage must have been under individual health insurance coverage, a group health plan, governmental plan or church plan or health insurance coverage offered in connection with any such plan; **AND**
3. Your most recent coverage cannot have been terminated for non-payment of premiums or fraud; **AND**
4. You cannot have other health insurance coverage or be eligible for coverage under a group health plan, Medicare, or Medicaid; **AND**
5. You have elected and exhausted COBRA or similar state continuation of benefits coverage, if it was available to you.

\* Creditable coverage includes group health plans, qualifying health insurance coverage, Medicare, Medicaid, CHAMPUS/TRICARE, or other publicly sponsored program. If your most recent creditable coverage is individual health insurance, and the insurer offering it exited the individual health insurance market and canceled your coverage, then only 12 months, and not 18 months, of prior creditable coverage is required.

Please list the first names of all qualifying HIPAA Eligible Individuals. Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

## MEDICAL INFORMATION

*Has any person applying for coverage ever had, been told he or she had, sought or been advised to have treatment for, had followup visits for, or received medication for the following diseases or conditions by a medical or social practitioner. Medical or social practitioner includes licensed and non-licensed practitioners, including but not limited to: a doctor, nurse, chiropractor, podiatrist, optometrist, psychologist, social worker, osteopath. Please check the appropriate box beside each condition and provide details in the Medical Treatment History section for any conditions checked "yes". You must include all information about the medical history of all persons listed on this application for coverage. Any information that is left off this application could cause a covered service to be denied and/or could cause your coverage to be canceled.*

Yes No

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Immune system disorder including but not limited to Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or T cell abnormality? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Alcoholism or treatment for alcohol use within 10 years?  |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Blood disorder including but not limited to anemia, hemophilia or leukemia?   |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Cancer including but not limited to malignant tumor, Hodgkin's disease or melanoma?   |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Intestinal disorders including but not limited to Crohn's disease or ulcerative colitis?  |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Diabetes Mellitus?  |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Back disorders including but not limited to disc disorders, surgery or spinal curvature?  |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Drug addiction or treatment for drug use within the past 10 years?  |

Yes No

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | i. Brain disorders including but not limited to epilepsy, stroke or transient ischemic attack?   |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Heart or Circulatory disorders including but not limited to heart murmur, heart attack (infarction), angina, aneurysm or heart surgery?     |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Liver disorders including but not limited to chronic hepatitis, cirrhosis or fatty liver?   |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Kidney disorders including but not limited to chronic infection, renal failure or kidney stones?  |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Connective tissue disease such as lupus, pancreatic disorders, adrenal disorders, pituitary disorders or disorders of the lymphatic system? |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Lung disorders including but not limited to chronic bronchitis, tuberculosis, emphysema or COPD?  |
| <input type="checkbox"/> | <input type="checkbox"/> | o. Central nervous system disorders including but not limited to paralysis, multiple sclerosis or Parkinson's disease?                         |

Are you, your spouse, or any dependent children (whether named on this application or not) now pregnant?  Yes  No

Any abnormality of female organs or menstrual periods?  Yes  No

Date of last Pap test \_\_\_\_/\_\_\_\_/\_\_\_\_ Results:  Grade 1  Grade 2  Grade 3  Grade 4  Grade 5

Do any children to be covered have any birth defects, congenital disorders, chronic illnesses or are currently taking prescription medication? If so, please list in Section G. Also, specify in Section G if his/her immunizations are up to date.

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*In the past 5 years has any person to be covered ever had, been told he or she had, sought or been advised to have treatment for, had follow-up visits for or received medication for the following diseases or disorders? Please check the appropriate box beside each condition and provide details in Section G for any condition checked "Yes".*

Yes No

- a. Bone or muscle disorders including but not limited to arthritis, gout, fixation device or fibromyalgia?
- b. Respiratory disorders including but not limited to asthma, sleep apnea, allergies, sinusitis, or undergoing desensitization treatments?
- c. Disorders of the eyes, nose or throat including but not limited to blindness, nasal septal deviation or esophageal stricture?
- d. Joint disorders including but not limited to joint (knee, hip) replacement, fractures, or dislocation?
- e. Ear disorders including but not limited to deafness, tympanoplasty (tubes) or chronic ear infections?
- f. Gastrointestinal disorders including but not limited to gall bladder disease, ulcers, esophageal reflux or hernia?

Yes No

- g. High blood pressure elevated cholesterol, elevated triglycerides, low blood pressure, palpitations or other irregular heartbeat?
- h. Reproductive disorders including but not limited to uterine fibroids, endometriosis, infertility, testicle or prostate disorders?
- i. Nervous or mental disorders including but not limited to depression, anxiety, bipolar disorder, psychosis or mental retardation?
- j. Breast disorders including but not limited to cysts or tumors, abnormal mammograms, or breast implants?
- k. Thyroid disorders including but not limited to goiter, hypothyroidism or hyperthyroidism?
- l. Sexually transmitted diseases including but not limited to genital herpes, syphilis, gonorrhea or genital warts?

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***In the past 5 years has any person to be covered:***

Yes No

- Consulted a physician, psychotherapist, counselor or other provider for medical or surgical treatment, or advice for any condition not listed above?
- Had any symptoms, not listed above, which would cause you or any person named on this application, to seek diagnosis, care or treatment?

Yes No

- Received inpatient or outpatient hospitalization procedure or treatment?
- Been advised to have an operation / surgery which has not been performed, to enter a treatment program that has not been started or is currently being received or to have tests or procedures that have not been done?



**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 & frequency)	Beginning Date of Use	Ending Date of Use

***Has any person to be covered:***

Yes No

Gained or lost any weight during the last 12 months?

First Name: \_\_\_\_\_

Gained  Lost \_\_\_\_\_ lbs

First Name: \_\_\_\_\_

Gained  Lost \_\_\_\_\_ lbs

Used cigarettes, cigars, chewing tobacco or other tobacco products in the past 12 months?

First Name: \_\_\_\_\_

Average number of packs per day and/or quantity per day: \_\_\_\_\_

First Name: \_\_\_\_\_

Average number of packs per day and/or quantity per day: \_\_\_\_\_

Had a DUI conviction, drunken driving conviction or license revocation?

First Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Used illicit drugs including but not limited to marijuana, opiates, amphetamines, cocaine or hallucinogenic drugs within the past 7 years?

First Name: \_\_\_\_\_

Substance/Frequency: \_\_\_\_\_

Date of last use \_\_\_\_/\_\_\_\_/\_\_\_\_

Yes No

Been declined on a previous health or life insurance application within the past five years?

If "Yes", then please indicate why you were declined for health or life insurance. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In the past 5 years has anyone to be covered received disability benefits, compensation or pension because of illness or injury?

First Name: \_\_\_\_\_

First Name: \_\_\_\_\_

**PAYMENT INFORMATION**

*Payments Must Be Made Monthly*

**1st Payment – Credit Card**

Credit Card Type:  Visa  Master Card  Discover  American Express

Cardholder Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Verification Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Cardholder's Billing Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**Ongoing Payments – Checking Account Electronic Funds Transfer**

Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Primary Name on Bank Account: \_\_\_\_\_

Name of Financial Institution: \_\_\_\_\_

Branch Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Branch Phone Number: \_\_\_\_\_

## CERTIFICATION

**Please make sure to sign, initial and date each section where we have requested a signature from you or other persons applying for coverage to avoid delays in processing your application.**

I and my agent (if applicable) certify that I have read or have had read to me this completed application. I understand that any answer or statement made within this application that is untrue and is material to the risk assumed by Optima Health may prevent the recovery of benefits under the policy for that individual or individuals to be covered. Such answer or statement may also result in the termination or voiding of the policy back to its start date for the individual or individuals for whom the untrue and material information was provided.

**I understand that:**

1. No coverage will be in force until my application is approved by Optima Health and that the start date will be the date assigned by Optima Health;
2. Newly enrolled members will be subject to a pre-existing condition exclusion for the first twelve (12) months following their date of enrollment unless they have twelve (12) months of creditable coverage before enrollment. **To receive credit for your prior coverage, please try to obtain a Certificate of Creditable Coverage from your previous insurance carrier or your current or previous employer and submit it to Optima with this application.**
3. If there has been a 63-day or greater break in coverage within the last 12 months, I will not receive credit for any coverage which was in effect before that break in coverage.
4. If Maternity Coverage was chosen, conception must occur at least 6 months after the Maternity Coverage start date. If you are an "Eligible Individual," and conception had occurred prior to the start date, the 6 month waiting period is waived;
5. My enclosed premium will be applied to coverage for approved person(s); the premium will be refunded if no persons are approved for the coverage selected and no other coverage is accepted; and
6. If any person for whom coverage is sought incurs a change in medical condition during the time period between the application date and the date Optima Health underwriting approves the application, I must notify Optima Health in writing of such change. I understand that failure to do so can result in the policy being revoked and no payment or coverage for any claim incurred.

I understand that the policy that I am applying for is an individual health insurance policy. As such, I understand that the policy, if issued, shall not be used as an employer-provided health care benefit plan. I certify that no employer of any person covered under this policy may pay any premium for this coverage, directly or indirectly, including through wage adjustment. I understand that "employer" does not include a trade or business wholly owned by an individual or individual and spouse/domestic partner that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

I understand that premiums not paid in accordance with this provision shall result in the non-renewal or discontinuance of the policy issued from this application.

### Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

Please check and/or initial one of the following:

- This application is for coverage under an Optima Health Individual policy which if issued **will not replace other coverage presently in force.**
- This application is for coverage under an Optima Health Individual policy which if issued **will replace other coverage presently in force.** Please read the following regarding replacement coverage.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Optima Health. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

**The above "Notice to Applicant" was delivered to me on \_\_\_\_\_ (Date)**

**PLEASE NOTE: A copy of the "Notice to Applicant" was delivered to me upon signature.**

The undersigned applicant and agent (if an agent was involved) certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Applicant or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Spouse/Domestic Date Partner or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Agent if applicable (mm/dd/yyyy)

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Agency Number                      Agent Number                      Receipt Date

(\_\_\_\_\_) - (\_\_\_\_\_) - \_\_\_\_\_  
Telephone Number                      Fax Number                      Email Address

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**NOTICE: THIS IS A LIMITED BENEFIT DISCLOSURE FORM. PLEASE SIGN AND DATE BELOW. THE POLICY YOU ARE APPLYING FOR IN THIS APPLICATION DOES NOT MEET THE MINIMUM STANDARDS REQUIRED BY THE BUREAU OF INSURANCE, VIRGINIA STATE CORPORATION COMMISSION, FOR INDIVIDUAL ACCIDENT AND SICKNESS POLICIES.**

This policy does not meet the Virginia minimum standards for the following reason(s): The Copayment by a Member may exceed 25% of the covered charge.

I have read this limited benefit disclosure provision and realize that this policy does not meet minimum standards required by Virginia law and that it can only be sold as a LIMITED BENEFIT POLICY.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Applicant or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Spouse/Domestic Date Partner or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative (mm/dd/yyyy)

**AUTHORIZATION**

**The following Authorization must be signed by the applicant and all other adult persons, including adult dependents age 18 or older that are applying for coverage. If all applicants do not sign this Authorization coverage may not be issued. If any other adult person to be covered refuses to sign the Authorization, any coverage issued will not be extended to that person.**

I hereby certify that I have read or have had read to me, and that I have maintained a copy of 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 to Optima Health Insurance Company 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 Optima Health Insurance Company or agents of Optima Health Insurance Company upon receiving information can use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement, or a request for change in policy benefits. Any information received by Optima Health Insurance Company received pursuant to this application is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may not longer be protected by federal rules governing privacy and confidentiality.

I understand that 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 for 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 understand that coverage is not in force until the effective date shown on the Member ID card issued to me or my dependents. 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 Insurance Company any change in eligibility of my self and my dependents. I agree to provide proof of eligibility that is acceptable to Optima Health Insurance Company if requested.

I understand that I can revoke this Authorization at any time by giving written notice to Optima Health Insurance Company 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.

**If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative’s authority must be attached to the application.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Applicant or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Spouse/Domestic Date Partner or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative (mm/dd/yyyy)