OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

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FOR PLAN USE ONLY
Subscriber #:
Date:

Optima Health Plan | *OptimaFit*
Application for Individual Health Coverage

New Applicant Change/modification of existing polic

Effective Date: _____

Member Name: _____

Member Number: _____

IMPORTANT:

- Incomplete information will **delay enrollment.** Please complete all sections in blue or black ink.
- Social Security numbers are to be provided for the primary subscriber, spouse and dependent child(ren) covered by this plan.
- If you are adding or removing a spouse or dependent **please attach supporting documentation.**
- Please note that this application is **not valid** if your intent is to enroll on a plan that is offered on the Health Insurance Marketplace. For those plans, please vist *www.healthcare.gov/marketplace/individual*.

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT (Check all that apply)

Change/Correction: ☐ Name Change ☐ Plan Reinstatement ☐ Address Change ☐ Plan Change ☐ Telephone Change ☐ Date of Birth Correction ☐ E-mail Address

Date of Qualifying Event: *(mm/dd/yyyy)*

Add Dependent(s) ☐ Marriage ☐ Newborn ☐ Adoption ☐ Loss of Coverage ☐ Other: Please note:

Remove Dependent(s) ☐ Marriage ☐ Divorce ☐ Medicare ☐ Death ☐ Age Out (26 and 65) ☐ Other: Please note:

B. PLAN SELECTION- POLICY DEDUCTIBLE and/or COINSURANCE

Optima Health Plan
OptimaFit Plan Options

☐ OptimaFit Gold 600	☐ OptimaFit Gold 1000	☐ OptimaFit Gold 1000 25
☐ OptimaFit Gold 1400	☐ OptimaFit Gold 1950 HSA	
☐ OptimaFit Silver 2000 HSA	☐ OptimaFit Silver 2600 25 20%	☐ OptimaFit Silver 3000 25
☐ OptimaFit Silver 4000 20%		
☐ OptimaFit Bronze 4500 HSA	☐ OptimaFit Bronze 5000 HSA	☐ OptimaFit Bronze 5500 HSA
☐ OptimaFit Bronze 6500 25	☐ OptimaFit Bronze 6850	

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C. PRIMARY APPLICANT INFORMATION *(PLEASE PRINT LEGAL NAME)*

- ***If this is a child only application, please include the Parent/Guardian name, address, date of birth, relationship to child and primary phone number in this section.***

Last Name:	First Name:	Middle Initial:

Home Address: *(no P.O. Box)*

City:	State:	Zip Code:

Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female	Primary Phone:	Secondary Phone:

Mailing Address: *(If different from home address above)*	City:	State:	Zip Code:

Email Address: _____

☐ I agree to accept electronic communications notifying me of important health plan information, including but not limited to, the Certificate of Insurance, Electronic Explanation of Benefits, plan updates and Uniform Summary of Benefits documents. By checking this box you agree to accept electronic communications

Primary Care Physician: (PCP)

If applying for Optima Health Plan Health Maintenance Organization (HMO) please select a primary care physician from the Plan's Provider Directory for each family member listed. The Optima Health Preferred Provider Organization (PPO) Plans do not require primary care selection.

PCP Last Name:	PCP First Name:

Provider Number: *(If known)* Current Patient? ☐ Yes ☐ No

If you are 18 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

Parent/Guardian Information *(if child only application)* ***Relationship to Child:*** ◯ Parent ◯ Guardian

Parent/Guardian Last Name:	Parent/Guardian First Name:	Date of Birth: *(mm/dd/yyyy)*

Home Address: *(no P.O. Box)*	*City:*	*State:*	*Zip Code:*

D. HEALTH SAVINGS ACCOUNT *(if applicable)*

Health Savings Account (HSA) Administration- If you have chosen the **Equity/HSA** eligible high deductible plan, you are eligible to establish a Health Savings Account (HSA). HealthEquity is Optima Health's preferred vendor for HSA account administration. *Do you want to establish a HSA account?*

Effective date: *(mm/dd/yyyy)* _____

☐ Yes, please DO establish a health savings account for me with HealthEquity.

☐ No, please DO NOT establish a health savings account for me with HealthEquity.

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E. ALTERNATE MAILING ADDRESS

If your spouse or any dependent should receive plan information to an address other than that listed under Section C Primary Applicant Information, please provide that address and the plan member's name.

Applicable Member:	Alternate Mailing Address:	City:	State:	Zip Code:

- *For additional addresses, please reprint this page and continue to fill out for additional policy members.*

F. FAMILY INFORMATION

Please complete only if your spouse and/or dependent children are applying for coverage.

- If enrolling dependents, how many? _____

SPOUSE ◯ Add ◯ Cancel **Use Alternate Mailing Address for this member?** ◯ Yes ◯ No

Last Name:	First Name:	Middle Initial:

Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female	Primary Phone:	Secondary Phone:
	Email Address:	

NOTE: Primary Care Physician: (PCP) If applying for Optima Health Plan Health Maintenance Organization (HMO) please select a primary care physician from the Plan's Provider Directory for each family member listed. The Optima Health Preferred Provider Organization (PPO) Plans do not require primary care selection.

PCP Last Name:	PCP First Name:

Provider Number: *(If known)* Current Patient? ☐ Yes ☐ No

If you are 18 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

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CHILD 1 ◯ Add ◯ Cancel **Use Alternate Mailing Address for this member?** ◯ Yes ◯ No

Last Name:	First Name:	Middle Initial:

Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female	Primary Phone:	Secondary Phone:
	Email Address:	

Primary Care Physician (PCP): *(If needed)*

PCP Last Name:	PCP First Name:

Provider Number: *(If known)* Current Patient? ☐ Yes ☐ No

If you are 18 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

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F. FAMILY INFORMATION *(continued)*

CHILD 2 ◯ Add ◯ Cancel **Use Alternate Mailing Address for this member?** ◯ Yes ◯ No

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No / Disabled: ☐ Yes ☐ No
Gender: ☐ Male ☐ Female	Primary Phone:	Secondary Phone:
	Email Address:	

Primary Care Physician (PCP): *(If needed)*

PCP Last Name:	PCP First Name:
Provider Number: *(If known)*	Current Patient? ☐ Yes ☐ No

If you are 18 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

CHILD 3 ◯ Add ◯ Cancel **Use Alternate Mailing Address for this member?** ◯ Yes ◯ No

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No / Disabled: ☐ Yes ☐ No
Gender: ☐ Male ☐ Female	Primary Phone:	Secondary Phone:
	Email Address:	

Primary Care Physician (PCP): *(If needed)*

PCP Last Name:	PCP First Name:
Provider Number: *(If known)*	Current Patient? ☐ Yes ☐ No

If you are 18 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

CHILD 4 ◯ Add ◯ Cancel **Use Alternate Mailing Address for this member?** ◯ Yes ◯ No

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No / Disabled: ☐ Yes ☐ No
Gender: ☐ Male ☐ Female	Primary Phone:	Secondary Phone:
	Email Address:	

Primary Care Physician (PCP): *(If needed)*

PCP Last Name:	PCP First Name:
Provider Number: *(If known)*	Current Patient? ☐ Yes ☐ No

If you are 18 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

- *If you have more than four (4) dependents please reprint this page and continue to fill out the information requested for all eligible dependents.*

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4417 Corporation Lane
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G. OTHER COVERAGE INFORMATION *(Required before enrollment can be completed.)*

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

◯ No If NO, skip to section H.

◯ Yes If YES, then please provide the following information about that coverage.

Insured Person (Name):	Identification (Policy) No.
Effective Date: (mm/dd/yyyy)	Name of employer or organization providing coverage:
Name of Insurance Company:	List anyone applying for coverage who will also be covered by this Insurance.

If Medicare Coverage:

If more than one person has Medicare Coverage, please reprint this page and complete the information requested.

Covered Person: (Name)	HIC Number:
Effective Date: Part A (mm/dd/yyyy)	Effective Date: Part B (mm/dd/yyyy)

Eligible due to: ◯ Age ◯ Disability ◯ 65 or over ◯ Working ◯ Retired

◯ End Stage Renal Disease (ESRD) ◯ Disability & Current ESRD

Month/Year: Month/Year:

- *If you have a family member who is enrolled on more than one additional health plan, please reprint this page and continue to fill out the additional coverage information for any coverage that will be active in addition to the plan you are applying for.*

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

I confirm that I have read this replacement notice and have checked and/or initialed one of the following regarding my application:

☐ 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 additional information 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. 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. 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. 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.

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H. INITIAL PAYMENT INFORMATION- Please select one payment type

CREDIT CARD *(Initial Payment ONLY)* ◯ Visa ◯ Master Card

Cardholder Name: *(Exactly as shown on card)*			
Credit Card Number:	CVV Code:	Expiration Date: *(mm/yyyy)*	
Cardholder's Billing Address:	City:	State:	Zip:

AUTOMATIC BANK DEDUCTION

Banking Information

If your banking information is different for your initial payment and your ongoing electronic payments, please fill out the next page and provide the information for ongoing payment transactions.

Bank Routing Number:	Bank Account Number:		
Primary Name on Bank Account:			
Name of Financial Institution:	Branch Phone Number:		
Branch Address:	City:	State:	Zip:

CHECK, MONEY ORDER, OR CASHIERS CHECK

To ensure proper posting, please include member name, member number, and invoice number (if applicable) on Check, Money Orders, or Cashiers Check.

Mail Payment to:
Optima Health
[4456 Corporation Lane
Suite 336
Virginia Beach, VA 23462]

MONEYGRAM

Make convenient premium payments at MoneyGram Locations across Virginia,
Including most 7-Eleven, CVS, Farm Fresh and Wal-Mart locations.
(No service fees apply)

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I. ON-GOING MONTHLY PAYMENT INFORMATION- Payments Must Be Made Monthly

AUTOMATIC BANK DEDUCTION

Banking Information

If your banking information is different for your initial payment and your ongoing electronic payments, please fill out the previous page and provide the information for the initial payment transaction.

Bank Routing Number:	Bank Account Number:		
Primary Name on Bank Account:			
Name of Financial Institution:	Branch Phone Number:		
Branch Address:	City:	State:	Zip:

CHECK, MONEY ORDER, OR CASHIERS CHECK

To ensure proper posting, please include member name, member number, and invoice number (if applicable) on Check, Money Orders, or Cashiers Check.

Mail Payment to:
Individual Product OHP
[PO Box 791264
Baltimore, MD 21279-1264]

PRE-PAID DEBIT

Payments with Pre-Paid Debit Cards: Calls must be made monthly to [(757)687-6434] or [(888)737-5479]

MONEYGRAM

Make convenient premium payments at MoneyGram Locations across Virginia,
Including most 7-Eleven, CVS, Farm Fresh and Wal-Mart locations.
(No service fees apply)

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J. CERTIFICATION

The following section must be signed and dated by the primary applicant and spouse (if applicable).

I, and my agent (if applicable), hereby certify that I have read, or have had read to me, the completed application; and that I have maintained a copy of the completed application; and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under this policy. I understand that no coverage will be in force until Optima Health determines eligibility for coverage, and notifies me of the first fective date of coverage. I understand that my enclosed premium will be applied to coverage for eligible person(s); and I understand that the premium will be refunded if no persons are eligible for coverage selected and no other coverage is accepted. I also understand that premiums not paid in accordance with this provision, and the terms of the policy, will result in the non-renewal or discontinuance of the policy issued from this application.

I understand that the policy that I am applying for is an individual health insurance policy, and I understand that the policy, if issued, shall not be used as an employer provided healthcare 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 ñemployerò does not include a trade of business wholly owned by an individual or individual and spouse 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 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 any change in eligibility of myself and my dependents. I agree to provide proof of eligibility that is acceptable to Optima Health if requested.

If a legal representative signs on behalf of the applicant or any other person to be covered, the legal representativeôs signature constitutes an attestation that the legal representative possesses the authority to sign on behalf of the individual.

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4417 Corporation Lane
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J. CERTIFICATION *(continued)*

If you or any of your covered dependents are covered by more than one health Plan benefits under your Optima Health plan will be coordinated so that the same health care services don't get paid for twice. When Optima Health is the primary payor, we will pay the benefits described in your coverage policy. When we are the secondary payor, we will determine our allowable charge; and after the primary plan pays, we will pay what is left of our allowance, up to our regular benefit.

The following section must be signed and dated by the primary applicant and spouse (if applicable).

Signature of Primary Applicant *or print, sign name, and specify title* of Legal Representative:	Date: (mm/dd/yyyy)
Signature of Spouse *(if applicable) or print, sign name, and specify title* of Legal Representative:	Date: (mm/dd/yyyy)
Signature of Dependent over the age of 18 *(if applicable) or print, sign name, and specify title* of Legal Representative:	Date: (mm/dd/yyyy)
Print Agent name if applicable:	Date: (mm/dd/yyyy)
Signature of Agent if applicable:	Date: (mm/dd/yyyy)

Agency Number:	Agent Number:	Receipt Date: (mm/dd/yyyy)
Primary Phone:	Fax Number:	
Email Address:		

Print Form

Clear All Form Fields

Save Form