OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

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FOR PLAN USE ONLY
Subscriber #:
Date:

Optima Health Plan and Optima Health Insurance Company
Employee Health Questionnaire

IMPORTANT:

- **ONLY** complete this form if your employer has 51 or more total employees AND less than 25 of those employees are enrolling on the plan.
- Return this form with your completed member application.

INFORMATION (PLEASE PRINT LEGAL NAME)

Please provide the name of each person listed on your completed member application:

Employee	Last Name	First Name	Middle Initial
Spouse	Last Name	First Name	Middle Initial
Child 1	Last Name	First Name	Middle Initial
Child 2	Last Name	First Name	Middle Initial
Child 3	Last Name	First Name	Middle Initial
Child 4	Last Name	First Name	Middle Initial

Optima Health Plan Selection:
HMO/POS Products Underwritten by Optima Health Plan

- ☐ Vantage *(HMO)*
- ☐ Equity Vantage *(HMO)*
- ☐ Design Vantage *(HMO)*
- ☐ POS/POSA *(POS)*
- ☐ Equity POS/ POSA *(POS)*
- ☐ Design POS/ POSA *(POS)*
- ☐ Vantage Direct *(HMO)*
- ☐ POS Direct *(POS)*
- ☐ Equity Vantage Direct *(HMO)*
- ☐ Equity POS Direct *(POS)*
- ☐ Vantage Select *(HMO)*
- ☐ POS/POSA Select *(POS)*
- ☐ Design Vantage Select *(HMO)*
- ☐ optional plan name HMOPOS
- ☐ optional plan name HMOPOS

Optima Health Insurance Company Plan Selection:
PPO Products Underwritten by Optima Health Insurance Company

- ☐ Plus *(PPO)*
- ☐ Out-of-Area Plus *(OOAPPO)*
- ☐ Design Plus *(PPO)*
- ☐ optional plan name PPO
- ☐ Out-of-Area Design Plus *(OOAPPO)*
- ☐ Equity Plus *(PPO)*
- ☐ Out-of-Area Equity Plus *(OOAPPO)*

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

A. HEALTH QUESTIONS

(TO BE COMPLETED BY EMPLOYEE FOR EMPLOYEE AND ALL DEPENDENTS TO BE COVERED)

SECTION 1: Within the past 5 years, have you, or any person on your completed application, had or been treated for the following diseases or impairments? Please check the appropriate box beside the condition and provide details in SECTION B 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 _____/_____/_____)	☐ ☐ Acquired Immune Deficiency Syndrome (AIDS)	☐ ☐ Allergies
☐ ☐ Nervous/Mental or Psychological Disorder	☐ ☐ Hemophilia	☐ ☐ Sleep Apnea
☐ ☐ Multiple Sclerosis	☐ ☐ Gout	☐ ☐ Cerebral Palsy
☐ ☐ High Cholesterol	☐ ☐ Heart Problems	☐ ☐ Cystic Fibrosis
☐ ☐ High Blood Pressure	☐ ☐ Thyroid Trouble	☐ ☐ Emphysema
		☐ ☐ Respiratory Disorders
		☐ ☐ Circulatory Problems

Additional Information About You and Your Dependents:

	Height		Weight		Height		Weight
Employee:	ft.	in.	lbs.	**Spouse:**	ft.	in.	lbs.
Child 1:	ft.	in.	lbs.	**Child 2:**	ft.	in.	lbs.
Child 3:	ft.	in.	lbs.	**Child 4:**	ft.	in.	lbs.

1. Within the past five (5) years, have you, or any person named on your completed application, consulted a physician or other provider for medical or surgical treatmentor advice for any condition NOT listed in SECTION 1? ☐ Yes ☐ *No*
   (*If Yes,please provide details in SECTIONS B (a) and B (b).*
2. Within the past five (5) years, have you, or any person named on your completed application, been advised to have an operation which has not been performed or to enter a treatment program not currently being received? ☐ Yes ☐ *No*
   (*If Yes,please provide details in SECTIONS B (a) and B (b).*
3. Within the past five (5) years, have you, or any person named on your completed application, been declined on a previous health insurance application? ☐ Yes ☐ *No*
   (*If Yes,please provide details in SECTIONS B (a) and B (b).*

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B.(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 form.

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

B. (b) MEDICAL TREATMENT HISTORY

If you checked "Yes" to any part of SECTION 1, please provide complete information regarding diagnosis, condition, or treatment – include all hospitalizations, surgery, and diagnostic testing. If you need more space, please attach addiotional documentation to this form.

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

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C. 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 his/her, the completed application and realizes that any act or practice that constitutes fraud or intentional material misrepresentation of fact in this application may result in loss or rescission of coverage. I acknowledge that all claims relating to such fraudulent act, practice or intentional material misrepresentations of fact will become my responsibility if incurred after termination or as a result of rescission.

I understand and agree that Optima Health Plan or Optima Health Insurance Company, as checked on page 1 of this application, will rely upon the above information and answers as the basis for establishing group premium rates for health care coverage.

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 knowledge of my health or the health of my spouse and/or dependents as listed on my completed member application to disclose such information to the extent permitted by law to Optima Health Plan or Optima Health Insurance Company, as checked on page 1 of my completed member application, for the purpose of compiling an accurate evaluation of this application and to establish group premium rates for the group. This authorization does not permit the use or disclosure of psychotherapy notes. Authorization to disclose information for the payment of claims is valid for the term of coverage and 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 I may be contacted by Optima Health Plan or Optima Health Insurance Company, as checked on page 1 of my completed member application, to obtain additional follow-up information on health conditions disclosed in Section B of this questionnaire for me, my spouse and/or my covered dependents.

I understand that I or my authorized representative may receive a copy of this authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

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. 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 coverage in force and that coverage is not in force if an application for 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 I am obligated to select a Plan-participating primary care physician for myself and for my covered dependents if choosing Optima Health Plan HMO or Optima Health Plan POS/POSA. I understand that it is my responsibility to report to the plan indicated on page 1 of this application any change in eligibility of my dependents. If requested, documentation will be supplied. I also understand that I am obligated to pay applicable Copayment or Coinsurance at the time services are rendered.

Employee Name (*Please Print*)	Company name:	
Employee Signature in ink	**Date:**	Daytime Phone:

Print Form **Save Form**

Reset/Clear Form

Optima Health Alternative Language Options for Notices and other Written Information

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:
ማሳሰቢያ፡
አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:
إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجانًا. اتصل بالرقم 1-855-687-6260.

Bengali/Bangla:
লক্ষ্য করবেনঃ যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন– 1-855-687-6260।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:
ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:
ધ્યાન આપો : જો તમે ગુજરાતી બોલી છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કૉલ કરો.

Hindi:
ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:
CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:
GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.

Kru/Bassa:
YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:
ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນໍາໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:
កំណត់សំគាល់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:
SHOOH: Diné Bizaad bee yáníłti'go doo bą́ą́h ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'ą́. Kojį' hólne' 1-855-687-6260.

Persian/Farsi:
توجه:
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:
ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:
DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 numaralı telefonu arayın.

Urdu:
توجہ دیں:
اگر آپ اُردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:
KÉÉRE:
Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Pe 1-855-687-6260