OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401

Optima Health Insurance Company
Optima Equity Plus
Enrollment Application

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

If you are enrolling your spouse or your children, read this first!

The following situations require that you provide additional information or documentation so that your spouse, or your children up to age 26 can be enrolled in your health plan. Without this information your enrollment and I.D. cards may be delayed.

Continuation Of Coverage For Children With A Disability:

Children over age 26 with a mental or physical disability will continue to be eligible for coverage. You will need to include a written statement from the child's physician with this application. Call member services for additional information.

Check your application carefully to be sure all birthdays and Social Security numbers are correct.

Please make sure to include birth dates and Social Security numbers for each person who will be covered under the Plan.

Notice of Special Enrollment Opportunity for Children under Age 26.

Children under age 26 whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in your Optima Health group plan. You may request enrollment for such children for 30 days from your group effective date. Enrollment will be effective on the first day of your Optima Health group coverage. For more information contact Optima Health member services.

Notice of Lifetime Limits and Opportunity to Enroll

Lifetime limits on the dollar value of benefits under Optima Health no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan will have an opportunity to enroll in the Plan. Individuals have 30 days from your group effective date to request enrollment. For individuals who enroll under this opportunity, coverage will take effect not later than the first day of the Plan coverage effective date. For more information contact Optima Health member services.

Clear Form

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Coordination of Benefits Information Page

* Please retain a copy of this coordination of benefits page for your records.

Applicant's Name: _____ Soc. Sec. #: _____

Date of Birth: _____

NOTE: Complete section1 and section 3 if you have additional commercial insurance.
Complete section 2 and section 3 if you have Medicare.

SECTION 1 (Commercial Insurance)

Name of other Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____ Effective Date: _____

Employer: _____

Group Number: _____

Policyholder's Name: _____

Birthdate: _____

List family members covered by this insurance: _____

SECTION 2 (Medicare Information)

Applicant: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

Spouse: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

SECTION 3

I hereby certify that except as reported above, no service or payments are provided or are recoverable through any other group insurance or service plan.

Signature of Applicant:	**Date:**

OptimaHealth
www.optimahealth.com

FOR PLAN USE ONLY
Subscriber #: _____
Date: _____

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IMPORTANT: Incomplete information will delay enrollment. Please use a ball point pen, press firmly and print clearly.

Section 4 To be completed by employer Group No. _____ (For Office Use Only) Sub Group No. _____ (For Office Use Only)

◯ **NEW** ◯ **Open Enrollment** ◯ **Continuation of Coverage** ◯ **C.O.B.R.A.** ◯ **PCP or Address Change**

◯ **Cancel All** ◯ **Add Dependent/Spouse** ◯ **Cancel Dependent/Spouse** ◯ **Reinstatement**

Employer Name: _____ **Effective/Expiration Date of Coverage:** _____ **Employee's Social Security No.** _____ **Hire Date:** _____

Section 5 TO BE COMPLETED BY EMPLOYEE- **(PLEASE PRINT LEGAL NAME)**

Last Name: _____ First Name: _____ Middle Init. _____

Address: _____ Primary Language: _____

City/State/Zip: _____

Primary Phone: ( ) _____ Secondary Phone: ( ) _____

Section 6 **Health Savings Account (HSA) Administration-** If you have chosen the Equity 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.

Do you want to establish a HSA account? Effective Date: _____

☐ 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.

Section 7 **Additional Coverage-**

REQUIRED INFORMATION TO BE COMPLETED BY EMPLOYEE FOR ALL PERSONS LISTED BELOW.

Will any of the persons listed below have any other medical health insurance in addition to Optima Health Plan, when this coverage takes effect? ☐ Yes ☐ No

If Yes, please complete Sections 1, 2, and 3 on the Coordination of Benefits form attached. If you have other health coverage and have elected a Health Savings Account (HSA), consult your tax advisor on your eligibility for contributing to an HSA.

Section 8 **Communication-**

Please select the method in which you would prefer to receive communications from Optima Health.

	Print	**Electronic**	
EOBs: *Explanation of Benefits*	☐	☐	**Email Address:** ***(Required)***
SBC: *Summary of Benefits & Coverage*	☐	☐	_____
Other Communications: *Newsletters etc.*	☐	☐	

Section 9

Please list below all persons to be covered by the enrollment application

Social Security No.		Last Name	First Name, MI	Date of Birth MO/DAY/YR	M/F
	SELF				
	SPOUSE				
	CHILD				
	CHILD				
	CHILD				
	CHILD				

IF ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE) _____

Section 10 AUTHORIZATION

I am applying for Optima Health Insurance Company (OHIC) coverage for myself and the family members listed, and agree that once issued I and my family members will abide by the provisions of coverage in the Group Policy and Certificate of Insurance under which we will be enrolled.

I understand that misrepresentation in answering questions on this application, or non-payment of premiums may result in cancellation of coverage. I understand that this application serves as a contract between myself and OHIC, and that all monies will be returned if the application is not accepted.

I authorize any physician, hospital, pharmacy, or other provider of health services or supplies, to disclose to OHIC medical and other information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. I also give OHIC the right to receive from, and release information to, other insurance companies needed to administer coordination of benefits (COB) provisions under the Group Policy.

I understand that OHIC upon receiving information can use it to evaluate eligibility for coverage, a claim for benefits, a request for change in policy benefits, or administer COB. 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.

Any information received by OHIC 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 and agree that no benefits shall take effect until this application is approved by OHIC and an Optima Health ID card with an effective date of coverage has been issued.

I understand that it is my responsibility to report and verify to OHIC any change in the eligibility of myself or my covered family members. If requested, I agree to supply acceptable documentation. I also understand that I am obligated to pay applicable copayments, coinsurance or deductible at the time services are rendered.

I certify that I have maintained a copy of this completed application for my records. I understand that this application shall become a part of the Group Policy. I further 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.

I understand that, for the purpose of collecting information in connection with this application, this authorization is valid for 30 months from the date of my signature; and for the purpose of collecting information in connection with a claim for benefits this authorization is valid for the term of coverage of the policy.

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____

Clear Form Print Form