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OptimaHealth
4417 Corporation Lane
Virginia Beach, VA 23462

FOR PLAN USE ONLY
Subscriber #:
Date:

Optima Health Plan and Optima Health Insurance Company Enrollment Application and Waiver 51-100 Coordination of Benefits

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

- ☐ Vantage *(HMO)*
- ☐ POS/POSA *(HMO/POS)*
- ☐ Equity Vantage *(HMO)*
- ☐ Design Vantage *(HMO)*

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

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

IMPORTANT:
- Incomplete information will **delay enrollment.** Please complete all sections in blue or black ink.
- Social Security numbers are **required** for the primary subscriber, spouse if over the age of forty, and disabled dependent child(ren) if over the age of forty.
- If you are adding or removing a spouse or dependent **please attach supporting documentation.**

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 Name:	Group Number:	Subscriber Number:
Benefit Administrator Signature- Required		Status: ☐ Hourly ☐ Salary

Date Hired: *(mm/dd/yyyy)*	Coverage Cancellation Date: *(mm/dd/yyyy)*	Effective Date of Coverage: *(mm/dd/yyyy)* *(new hire waiting period must be satisfied)*

B. EMPLOYEE INFORMATION (PLEASE PRINT LEGAL NAME)

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)*

Primary Phone: Secondary Phone: Gender: ☐ Female ☐ Male Disabled: ☐ Yes ☐ No

Primary Care Physician: (PCP)

If applying for Optima Health Plan Health Maintenance Organization (HMO) or the Optima Health Point of Service Plan (POS/POSA), please select a primary care physician from the Plan's Provider Directory for each family member listed. The Optima Health Preferred Provider Organization (PPO) and Optima Health Out-of-Area Preferred Provider Organization Plans (OOA) do not require primary care selection.

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

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.

OptimaHealth

Subscriber Name:
Employer Name:

C. WAIVER OF EMPLOYEE AND/OR DEPENDENT HEALTH COVERAGE

If you are electing coverage for yourself and dependents, you may disregard this section.

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.

Please check the one which applies

- ☐ I decline coverage for myself (and my dependents, if any)
- ☐ I decline coverage for my children only.
- ☐ I decline coverage for my spouse 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: (mm/dd/yyyy)

D. HEALTH SAVINGS ACCOUNT *(Equity Vantage and Equity Plus plans ONLY)*

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?*

☐ **Yes**, please **DO** establish a health savings account for me with HealthEquity. **Effective date:** *(mm/dd/yyyy)* _____

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

E. ALTERNATE ADDRESS *Employee:* ☐ *Yes* ☐ *No* *Spouse/Dependents:* ☐ *Yes* ☐ *No*

If the employee, spouse or any dependent should receive correspondence, plan information or any other form of communication to an address other than that listed under ***Section B Employee Information***, please provide that here.

Alternate Address:	*City:*	*State:*	*Zip Code:*

F. SPOUSE AND DEPENDENT ENROLLMENT INFORMATION

NOTE: ***Primary Care Physician: (PCP)***

If applying for Optima Health Plan Health Maintenance Organization (HMO) or the Optima Health Point of Service Plan (POS/POSA), please select a primary care physician from the Plan's Provider Directory for each family member listed. The Optima Health Preferred Provider Organization (PPO) and Optima Health Out-of-Area Preferred Provider Organization Plans (OOA) do not require primary care selection.

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

Last Name:	First Name:	Middle Initial:

Social Security Number:	Date of Birth: *(mm/dd/yyyy)*

Primary Phone:	Secondary Phone:	Gender: ☐ Female ☐ Male	Disabled: ☐ Yes ☐ No

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

OptimaHealth

Subscriber Name:
Employer Name:

F. SPOUSE AND DEPENDENT ENROLLMENT INFORMATION *(continued)*

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

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	Gender: ☐ Female ☐ Male / Disabled: ☐ Yes ☐ No
PCP Last Name:	PCP First Name:	Provider Number: (If Known) / Current Patient? ☐ Yes ☐ No

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

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	Gender: ☐ Female ☐ Male / Disabled: ☐ Yes ☐ No
PCP Last Name:	PCP First Name:	Provider Number: (If Known) / Current Patient? ☐ Yes ☐ No

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

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	Gender: ☐ Female ☐ Male / Disabled: ☐ Yes ☐ No
PCP Last Name:	PCP First Name:	Provider Number: (If Known) / Current Patient? ☐ Yes ☐ No

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

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	Gender: ☐ Female ☐ Male / Disabled: ☐ Yes ☐ No
PCP Last Name:	PCP First Name:	Provider Number: (If Known) / Current Patient? ☐ 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.*

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.

OptimaHealth

Subscriber Name:
Employer Name:

G. OTHER COVERAGE INFORMATION *(continued)*

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) Month/Year: ☐ Disability & Current ESRD Month/Year:

H. CERTIFICATION AND AUTHORIZATION

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 coverage will be under my employer's group sponsored plan. 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 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 as eligible for coverage, I authorize my employer to made 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 hereby authorize any provider of health services, or any insurance company that has any records or knowledge of my health or my dependents health to give to Optima Health Insurance Company or Optima Health Plan, as checked on page one, any such information for the purposes of administering coordination of benefits provisions, and for the payment of claims once enrolled. 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 any information received by Optima Health Insurance Company or Optima Health Plan 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 no 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 eligibility for coverage, policy reinstatement, or a request for a change in policy benefits that this Authorization is valid for thirty (30) months from the date the authorization is signed. 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 or Optima Health Plan any change in eligibility of myself and my dependents. I agree to provide proof of eligibility that is acceptable to Optima Health if requested.

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.

Signature of Employee or print, sign name, and specify title of Legal Representative: **Date:** *(mm/dd/yyyy)*

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

I. HEALTH QUESTIONS

(TO BE COMPLETED BY EMPLOYEE FOR EMPLOYEE AND ALL DEPENDENTS LISTED IN SECTIONS B & F)

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 J 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 this application, consulted a physician or other provider for medical or surgical treatmentor advice for any condition NOT listed in SECTION I? ☐ Yes ☐ *No*
   (If Yes,please provide details in SECTIONS J (a) and J (b).
2. 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 toenter a treatment program not currently being received? ☐ Yes ☐ *No*
   (If Yes,please provide details in SECTIONS J (a) and J (b).
3. Within the past five (5) years, have you, or any person named on this application, been declined on a previous health insurance application? ☐ Yes ☐ *No*
   (If Yes,please provide details in SECTIONS J (a) and J (b).

J.(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

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

J. (b) MEDICAL TREATMENT HISTORY

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

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

K. 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 this 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 this 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 this application, to obtain additional follow-up information on health conditions disclosed in Section J of this application 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:

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