OptimaHealth

Helpful Tips for Completing Your Enrollment Application

These tips are not part of the enrollment application and are meant to assist you as you fill out our enrollment application.

- Please complete the enrollment application in blue or black ink.
- Please print clearly and provide all required information.
- If you are electing coverage for yourself and all dependents you may disregard section B, not section D.
- Please attach any necessary supporting documentation, if you are adding or removing a spouse or dependent.

OptimaHealth

Clear Form

FOR PLAN USE ONLY
Subscriber #:
Date:

4417 Corporation Lane
Virginia Beach, VA 23462

Optima Health Plan
Enrollment Application and Waiver 2-50
Coordination of Benefits

Plan Selection:

◯ Vantage _____ ◯ POS/POSA _____

◯ Equity Vantage _____ ◯ Design Vantage _____

IMPORTANT:

Incomplete information will **delay enrollment.** Please complete all sections in blue or black ink.

- **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:
Benefit Administrator Signature- **Required**	
Subscriber Membership Number:	Date Hired: / Status: ☐ Hourly ☐ Salary
Effective Date of Coverage: *(mm/dd/yyyy)*	*(new hire waiting period must be satisfied)*
Coverage Cancellation Date: *(mm/dd/yyyy)*	

B. WAIVER OF EMPLOYEE AND/OR DEPENDENT HEALTH COVERAGE

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. If electing coverage for self and all dependents, I may disregard section D.

(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.

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B. WAIVER OF EMPLOYEE AND/OR DEPENDENT HEALTH COVERAGE *(continued)*

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)*

C. 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)*

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No

Primary Phone: Secondary Phone:

Primary Care Physician: *(PCP)*

Last Name: First Name:

Provider Number: *(If Known)* Current Patient? ☐ Y ☐ N

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

Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ 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.

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D. HEALTH SAVINGS ACCOUNT

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?

☐ 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. SPOUSE AND DEPENDENT ENROLLMENT INFORMATION

- *If enrolling dependents, how many?* _____

SPOUSE ☐ Add ☐ Cancel

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)*

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No

Primary Phone:	Secondary Phone:

Primary Care Physician: *(PCP)*

Last Name:	First Name:

Provider Number: *(If Known)* Current Patient? ☐ Y ☐ N

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

Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

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

CHILD 1

☐ Add ☐ Cancel

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)*

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No

Primary Phone:	Secondary Phone:

Primary Care Physician: *(PCP)*

Last Name:	First Name:

Provider Number: *(If Known)* Current Patient? ☐ Y ☐ N

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

Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

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CHILD 2

☐ Add ☐ Cancel

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)*

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No

Primary Phone:	Secondary Phone:

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

CHILD 2 *(continued)*

Primary Care Physician: *(PCP)*

Last Name:	First Name:
Provider Number: *(If Known)*	Current Patient? ☐ Y ☐ N

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
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program?	☐ Yes	☐ No

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CHILD 3 ☐ Add ☐ Cancel

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)*

Gender: ☐ Male ☐ Female	Disabled: ☐ Yes ☐ No

Primary Phone:	Secondary Phone:

Primary Care Physician: *(PCP)*

Last Name:	First Name:
Provider Number: *(If Known)*	Current Patient? ☐ Y ☐ N

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
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program?	☐ Yes	☐ No

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

CHILD 4 ☐ Add ☐ Cancel

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)*

Gender: ☐ Male ☐ Female Disabled: ☐ Yes ☐ No

Primary Phone:	Secondary Phone:

Primary Care Physician: *(PCP)*

Last Name:	First Name:

Provider Number: *(If Known)* Current Patient? ☐ Y ☐ N

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

Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ 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.*

F. 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 G.

☐ 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 Insurance Company:	Name of employer or organization providing coverage:

List anyone applying for coverage who will also be covered by this Insurance

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F. 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 ☐ End Stage Renal Disease (ESRD) Month/Year: ☐ Disability & Current ESRD Month/Year: ☐ 65 or over ☐ Working ☐ Retired

G. 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 Plan 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 Plan 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.

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G. CERTIFICATION AND AUTHORIZATION *(continued)*

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

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 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.

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

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)
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:		