Print Form Clear Form

FOR PLAN USE ONLY
Subscriber #:
Date:

OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

Optima Health Plan
Application for Individual Health Coverage

☐ New Applicant
☐ Change/modification of existing policy

Member Number: _____

Effective date: _____

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

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

Change/Correction:

☐ Name Change ☐ Address Change
☐ Telephone Change ☐ Date of Birth Correction
☐ E-mail Address ☐ Loss of Coverage
☐ Reinstatement ☐ Plan Change

Add Dependent(s)

☐ Marriage ☐ Newborn ☐ Adoption
☐ Other: *Please note:*

Remove Dependent(s)

☐ Marriage ☐ Divorce ☐ Medicare ☐ Death
☐ Other: *Please note:*

B. PLAN SELECTION- POLICY DEDUCTIBLE and/or COINSURANCE *(select one)*

Optima Vantage	Deductible			
Optima Vantage Equity	Deductible			
Optima Vantage Foursight	Deductible			

Optional Rider

☐ Add Morbid Obesity Rider ☐ Remove Morbid Obesity Rider

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C. PRIMARY APPLICANT 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)*

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:

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

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. FAMILY INFORMATION

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

- *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)*

U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female

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

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E. FAMILY 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)*

U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female

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

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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)*

U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female

Primary Phone:	Secondary Phone:

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E. FAMILY 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

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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)*

U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female

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

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E. FAMILY 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)*

U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female

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

- *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) ☐ Disability & Current ESRD ☐ 65 or over ☐ Working ☐ Retired

Month/Year: Month/Year:

G. PAYMENT INFORMATION- Payments Must Be Made Monthly

Select Payment Type

Payment can be made by Check, Money Order, Cashier's Check, Prepaid Debit Card, or Automatic Bank Deduction.

☐ **Automatic Bank Deduction**

For automatic bank deduction, please fill out the section below. This information will be used each month to deduct your premium payment. **Payments are drawn on or around the 8th of the month**

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** ☐ **Cashier's Check**

To ensure proper posting, please include **Member name, Member number, and Invoice number** (if applicable) on Checks, Money Orders, and Cashier's Checks.

Mail Payment to:

Optima Health
Attn: Billing Department
4456 Corportation Lane, Suite 336
Virginia Beach, VA 23462

☐ **Prepaid Debit Card** Prepaid Debit Card payments call **(757) 687-6434 or (888) 737-5479**

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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 no coverage will be in force until Optima Health determines eligibility for coverage, and notifies me of the first effective 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 the 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 “employer” does not include a trade or 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 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.

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.

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H. CERTIFICATION AND AUTHORIZATION *(continued)*

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

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:		

Print Form

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