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 2-100 Coordination of Benefits

Optima Health Plan Selection:

- ◯ Vantage *(HMO)*
- ◯ Equity Vantage
- ◯ Design Vantage
- ◯ POS
- ◯ Equity POS
- ◯ Design POS
- ◯ Vantage Direct
- ◯ POS Direct
- ◯ Equity Vantage Direct
- ◯ Equity POS Direct

Optima Health Insurance Company Plan Selection:

- ◯ Plus *(PPO)*
- ◯ Design Plus
- ◯ Equity Plus

IMPORTANT:

- Incomplete information will **delay enrollment.** Please complete all sections in blue or black ink.
- Social Security numbers are to be provided for the primary subscriber, spouse and dependent child(ren) covered by this plan.
- If you are adding a spouse or dependent due to a qualified event, **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)*	Effective Date of Coverage: *(mm/dd/yyyy)* *(new hire waiting period must be satisfied)*	Coverage Cancellation Date: *(mm/dd/yyyy)*

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), 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

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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Subscriber Name:
Employer Name:

C. WAIVER OF EMPLOYEE AND/OR DEPENDENT HEALTH COVERAGE

If you are electing coverage for your self 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 spouse only.
- ○ I decline coverage for my children 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?*

Effective date: _____ (mm/dd/yyyy)

○ **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.

E. ALTERNATE MAILING 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 Mailing 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), 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 Mailing 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

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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Subscriber Name:
Employer Name:

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

CHILD 1 ○ Add ○ Cancel **Use Alternate Mailing 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 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

CHILD 2 ○ Add ○ Cancel **Use Alternate Mailing 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 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

CHILD 3 ○ Add ○ Cancel **Use Alternate Mailing 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 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

CHILD 4 ○ Add ○ Cancel **Use Alternate Mailing 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 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.*

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Subscriber Name:
Employer Name:

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.

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

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 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 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 any change in eligibility of myself and my dependents. I agree to provide proof of eligibility that is acceptable to Optima Health if requested.

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 behalf of the individual.

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