OptimaHealth

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Virginia Beach, VA 23462
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Optima Health Plan
Optima Vantage
Enrollment Application

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

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

The following situations require that you provide additional information or documentation so that your spouse or your dependents can be enrolled in your health plan. Without these documents your I.D. cards will not be issued.

Enrolling outside open enrollment period
*** If new hire no further information is needed**

Qualifying Event Tips & documentation that may be required (do not send originals):

- □ Marriage (Marriage License)
- □ Birth (Birth Registration Certificate that establishes parentage)
- □ Adoption or Legal Guardianship change (Adoption Decree or Legal Guardianship Court Decree)
- □ Medical Child Support (Qualified Medical Child Support Order)
- □ Loss of Coverage ((Verification of Termination from prior insurance company)

Spouses or children with last names different from yours:

Be sure to include a copy (do not send the original) of *one* of these:

- □ Marriage License (spouse)
- □ Birth Registration Certificate that establishes parentage (dependents)
- □ Adoption Decree (dependents)
- □ Legal Guardianship Court Decree (dependents)
- □ Qualified Medical Child Support Order (dependents)

Dependents age 19 and over attending school on a full-time basis:

Be sure to include a copy (do not send the original) of *one* of these:

- □ Current Registration (showing total credit hours)

Handicapped dependents age 19 and over:

Handicapped dependents age 19 and over are eligible for continued coverage under other limited circumstances. Include a written verification of the handicap from a licensed physician. Call member services for additional information.

Check your application carefully to be sure all birthdays and Social Security numbers are correct, and that you have indicated your choice of PCP and your phone numbers.

If you have other health plan coverage you must complete the Coordination of Benefits page.

OptimaHealth®

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

❑ **New** ❑ **Open Enrollment** ❑ **Request for Individual Conversion** ❑ **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 B TO BE COMPLETED BY EMPLOYEE - **(PLEASE PRINT LEGAL NAME)**

Last Name _____ First Name _____ Middle Init. _____

Address _____Primary Language_____

City/State/Zip_____ Email_____

Home Phone (_____) _____ Work Phone (_____) _____

SECTION C

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 F, G, and H on the Coordination of Benefits page attached.

SECTION D Please list below all persons to be covered by the enrollment application. Choose a primary care physician by consulting your provider directory. You may choose a different primary care physician for each member of your family. We will need your choice of both a primary care physician and location in order to process this application.

SOCIAL SECURITY NO.		LAST NAME	FIRST NAME, M.I.	DATE OF BIRTH MO/DAY/YR	M or F	PRIMARY CARE PHYSICIAN & ID #	CURRENT PATIENT
	SELF			/ /		DR.	YES / NO
	SPOUSE			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO

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

SECTION E

I am applying for Optima Health Plan coverage for myself and the family members listed, and agree that I and my family members shall abide by the provisions of coverage in the Group Agreement and Evidence of Coverage under which we will be enrolled.

I understand that misrepresentation in answering the questions on this application or non-payment of premiums, copayment or coinsurance may result in cancellation of coverage. All benefits and exclusions are set forth in the Evidence of Coverage. I understand that this application serves as a contract between myself and Optima Health Plan, and that all the provisions outlined herein apply. All monies will be returned if the application is not accepted.

I authorize any physician or hospital to disclose to Sentara Health Plans,Inc., as agent for Optima Health Plan, information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. I understand by signing this form I give Optima Health Plan the right to receive and release information needed to administer the coordination of benefits (COB) provisions. I further understand and agree that no benefits shall take effect until this application is approved by Optima Health Plan. An Evidence of Coverage and Face Sheet will be issued. This application shall become a part of the Group Agreement. I understandthat I or my authorized representative may receive a copy of this enrollment application upon request. I agree that a photographic copy of thisauthorization 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.

I understand that it is my responsibility to report to Optima Health Plan any change in the eligibility of my dependents. I understand that all dependents listed are legally my responsibility as claimed with the I.R.S. If requested, documentation will be supplied. I understand that I am obligated to select a participating primary care physician for myself and my covered dependents and if I did not one will be assigned. I also understand that I am obligated to pay applicable copayments, coinsurance or deductible at the time services are rendered.

By signing below, I hereby acknowledge and certify that I have had a health plan with an out-of-network option offered and made available to me and have rejected same in favor of an HMO plan.

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____