Sentara Health Plans
PO Box 66189
Virginia Beach, VA 23466

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FOR PLAN USE ONLY
Subscriber #:
Date:

Employee Enrollment Application, Waiver and Coordination of Benefits

BusinessEDGE® Plans Administered by Sentara Health Administration, Inc.:

☐ Vantage *(HMO)*	☐ Vantage Design	☐ Plus HSA	☐ POS
☐ Vantage HSA	☐ Plus (PPO)	☐ Design Plus	☐ POS HSA

Specific Plan Benefit: _____

IMPORTANT:

- Sentara Health Plans has the right to revise rates (retroactively or prospectively), rescind or terminate your employer's Stop Loss Insurance Contract if you complete this form with false, incomplete or misleading information. Your employer may rescind you or your dependent's coverage if you complete this form with false, incomplete or misleading information.
- 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:
Plan 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 (TO BE COMPLETED BY EMPLOYEE, PLEASE PRINT LEGAL NAME.)

Last Name:	First Name:	Middle Initial:
Home Address:	City:	State: Zip Code:
Social Security Number:		Date of Birth: *(mm/dd/yyyy)*

Primary Phone:	Secondary Phone:	Gender:	Disabled:
Best time to call:	Best time to call:	☐ Female ☐ Male	☐ Yes ☐ No

Primary Care Physician: *(PCP)*

If applying for the Sentara Health Plans Health Maintenance Organization *(HMO)*, please select a primary care physician from the Plan's Provider Directory for each family member listed. The Sentara Health Plans Preferred Provider Organization *(PPO)* does 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 Summary Plan Description (SPD), 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:

B. EMPLOYEE INFORMATION *(continued)*

Go Paperless! Consent to Receive Electronic Communications

Please enter your email address to enroll in our Paperless Program. By enrolling, you consent to receive electronic communications from Sentara. This includes email communications and notice that copies of your electronic policy documents, explanation of benefits (EOBs) and other plan notices are available through your secure online Sentara Member Portal (www.Sentarahealth.com/ members) or the Sentara Mobile App instead of paper documents through personal delivery or the U.S. Mail. You do not have to enroll in our paperless program to enroll in the health plan.

Email Address: _____

By providing your email address above, you agree to accept electronic communications at that email address notifying you of important health plan information, including but not limited to, the Certificate of Insurance, Evidence of Coverage, Explanation of Benefits (EOBs), plan updates, and Uniform Summary of Benefits documents. You may revoke your consent to receive electronic communications or request a paper copy of any documents at any time.

Phone Notifications and Consent:

Phone Number: _____

By providing your phone number above you consent to allow Sentara and its representatives to contact you at that number, or any phone number you have provided to us on this application including mobile phone numbers. You understand that you are not required to agree and agreeing is not a condition of being a Sentara member or receiving health care. If you are not the subscriber to the phone number you provided, then you agree that you have obtained the subscriber's consent to receive these communications.

Communications directed to these phone numbers may be conducted using automated dialing/delivery devices, direct dial, text message, SMS or RCS messages, ringless voicemail, push notifications, and prerecorded or artificial voices. These communications may include, but may not be limited to, surveys, marketing messages to promote products and services provided by Sentara, reminders to renew before your plan expires, information regarding medication, wellness, preventive care, health plan enrollment, communication preferences, payment, and other information Sentara or its representatives believe may interest or be relevant to you. Content contained within these communications, which may include health information, will not be encrypted. Sentara will not charge you for these communications. Carrier message and data rates may apply. You may revoke your consent at any time. To opt out of phone calls, contact Sentara at 1-800-741-9910. To opt out of text messages, text STOP to short code 59270 or call 1-800-741-9910.

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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 Sentara Health Plans'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 Sentara Health Plans Health Maintenance Organization (HMO), please select a primary care physician from the Plan's Provider Directory for each family member listed. The Sentara Health Plans Preferred Provider Organization (PPO) does 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:	Disabled:
Best time to call:	Best time to call:	☐ Female ☐ Male	☐ Yes ☐ No

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

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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. CURRENT COVERAGE INFORMATION *(Required before enrollment can be completed.)*

Will the plan listed below remain in effect in addition to the coverage you are currently applying for?

☐ **NO**, the plan for which I am applying for will replace my current coverage listed below.

☐ **YES**, I will keep my current coverage listed below in addition to the coverage I am applying for.

☐ I currently do not have any health care coverage.

Insured Person *(Name)*:	Identification *(Policy)* No.
Effective Date: *(mm/dd/yyyy)*	Name of employer, organization or individual providing coverage:
Name of Insurance Company:	List anyone applying for coverage who will also be covered by this insurance.

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Subscriber Name:
Employer Name:

G. CURRENT 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)* ☐ Disability & Current ESRD

Month/Year: 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 Sentara Health Plans.

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 Sentara Health Plans 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, or a request for change in benefits, this authorization shall be valid for thirty (30) months from the date shown below.

I understand any information received by Sentara Health Plans 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 Summary Plan Description document under which we will be enrolled. I understand that it is my responsibility to report to Sentara Health Plans any change in eligibility of myself and my dependents. I agree to provide proof of eligibility that is acceptable to Sentara Health Plans if requested.

I understand that I can revoke this Authorization at any time by giving written notice to Sentara Health Plans 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)*

Sentara Health Plans

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Health Questionnaire

Group Number	Group Name	
Effective Date *(mm/dd/yyyy)*	Subscriber Membership Number	Subscriber Name

SECTION 1- HEALTH QUESTIONS/MEDICAL INFORMATION

(TO BE COMPLETED BY EMPLOYEE FOR EMPLOYEE AND ALL DEPENDENTS LISTED ON YOUR ENROLLMENT APPLICATION)

You may receive a telephone call from Sentara Health Plans to obtain additional information. Please provide detailed medical information on this form to reduce the need for a phone interview. Your answers will be strictly confidential. Tobacco use, height and weight are required for members/applicants ages 21 and older.

MEMBER	NAME	TOBACCO?	D.O.B.	GENDER	HEIGHT		WEIGHT
Employee		☐ Y ☐ N		☐ Male ☐ Female	**ft.**	**in.**	**lbs.**
Spouse		☐ Y ☐ N		☐ Male ☐ Female	**ft.**	**in.**	**lbs.**
Child 1		☐ Y ☐ N		☐ Male ☐ Female	**ft.**	**in.**	**lbs.**
Child 2		☐ Y ☐ N		☐ Male ☐ Female	**ft.**	**in.**	**lbs.**
Child 3		☐ Y ☐ N		☐ Male ☐ Female	**ft.**	**in.**	**lbs.**
Child 4		☐ Y ☐ N		☐ Male ☐ Female	**ft.**	**in.**	**lbs.**

1. Have you, your spouse or any dependent children (whether named on this application or not) been advised to have any further testing, consultation or treatment, operation or surgery which has not yet been performed? ☐ Yes ☐ No
   a. If yes, who? _____ What is the diagnosis? _____
   What are the treatment options?
2. Are you, your spouse or any dependent children (whether named on this application or not) now pregnant or in the process of adopting? ☐ Yes ☐ No
   a. If yes, who? Adoption date or Due date: *Date*

SECTION 2- MEDICAL PROFILE SUPPLEMENT CERTIFICATION

If you are an existing Sentara Health Plans member, please read and complete this section then stop. Signature is REQUIRED for underwriting review. If you are not currently enrolled with Sentara Health Plans, skip this section and proceed to the next page.

By my signature below, I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in terminations of my/or my dependent(s) coverage.

Employee Name (*Please Print*)	Company name:	
Employee Signature in ink	**Date:**	Daytime Phone:

Sentara® Health Plans

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Health Questionnaire

Group Number	Group Name	
Effective Date *(mm/dd/yyyy)*	Subscriber Membership Number	Subscriber Name

Section 1- HEALTH QUESTIONS/MEDICAL INFORMATION

(TO BE COMPLETED BY EMPLOYEE FOR EMPLOYEE AND ALL DEPENDENTS LISTED ON YOUR ENROLLMENT APPLICATION)

You may receive a telephone call from the home office to obtain additional information. Please provide detailed medical information on this form to reduce the need for a phone interview. Your answers will be strictly confidential.

Please provide details for any conditions checked "yes" in the Health Questions/Medical Information below in ***the Medical History Details section***. **Please provide information on past and current medical treatment history. If you need more space, please attach additional documentation to this application.**

1. In the past 5 years, have you or any person applying for coverage had, been told he or she had, sought, or been advised to have treatment for, had follow-up visits for, or received medication for the following diseases or conditions by a medical or social practitioner? Please check the appropriate box beside each condition and provide details in the **Medical History Details** section for any conditions checked "yes." You must include all information about the medical history of all persons listed on this application for coverage. Any information that is omitted from this application could cause a covered service to be denied and/or could cause your coverage to be canceled.

a.	**Autoimmune disease or connective tissue disorder** such as but not limited to lupus, HIV positive, AIDS, or ARC.	☐ Yes	☐ No
b.	**Arthritis** such as but not limited to rheumatoid, psoriatic, or ankylosing spondylitis.	☐ Yes	☐ No
c.	**Back disorder** such as but not limited to disk disease, fracture, sciatica, or spinal curvature.	☐ Yes	☐ No
d.	**Blood disorder** such as but not limited to anemia, leukemia, or hemophilia.	☐ Yes	☐ No
e.	**Cancer or malignant tumor** such as but not limited to Hodgkin's Disease, lymphoma, or melanoma.	☐ Yes	☐ No
f.	**Congenital disorder or birth defect** such as but not limited to Down Syndrome, or heart defect.	☐ Yes	☐ No
g.	**Digestive disorder** such as but not limited to ulcers, diverticulitis, Crohn's Disease, or ulcerative colitis.	☐ Yes	☐ No
h.	**Eye, ear, nose, or throat disorder** such as but not limited to esophageal stricture or varices, or thyroid disorder.	☐ Yes	☐ No
i.	**Female/Male disorders** such as but not limited to endometriosis, abnormal mammogram, PAP smear, abnormal PSA, or enlarged prostrate.	☐ Yes	☐ No
j.	**Genitourinary disorder** such as but not limited to prostatitis, bladder polyps, or urethral stenosis.	☐ Yes	☐ No
k.	**Heart or circulatory disorder** such as but not limited to heart attack, by-pass, stroke, or peripheral artery disease.	☐ Yes	☐ No
l.	**Kidney disorder** such as but not limited to stones, chronic nephritis, polycystic kidney disease, or renal failure.	☐ Yes	☐ No
m.	**Liver disorder** such as but not limited to hepatitis, cirrhosis, or fatty liver.	☐ Yes	☐ No
n.	**Muscle or joint disorder** such as but not limited to muscular dystrophy, myasthenia gravis, or joint replacement.	☐ Yes	☐ No
o.	**Neurological disorders** such as but not limited to epilepsy, multiple sclerosis, paralysis, or migraines.	☐ Yes	☐ No

Sentara® Health Plans

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Health Questionnaire

Section 1- HEALTH QUESTIONS/MEDICAL INFORMATION *(continued)*

p. **Pancreatic disorder** such as but not limited to pancreatitis or pancreatic insufficiency. ☐ Yes ☐ No

q. **Pituitary or adrenal disorder** such as but not limited to acromegaly, Cushing's Disease, or Addison Disease. ☐ Yes ☐ No

r. **Respiratory disorders** such as but not limited to asthma, COPD, tuberculosis, or cystic fibrosis. ☐ Yes ☐ No

2. Have you or any dependent applying for coverage had or have any of the following:

a. **Diabetes mellitus?** ☐ Yes ☐ No

If "yes", who has diabetes? _____ Type: ☐ Type 1 (juvenile) ☐ Type 2 (adult onset)

If "yes", select the treatment: ☐ diet controlled ☐ oral medication ☐ insulin Date Diagnosed? _____ *Date*

b. Received treatment for **alcohol or drug abuse** in the last 5 years? ☐ Yes ☐ No

If "yes", who? _____ ☐ Illegal Drugs ☐ Prescription Drugs ☐ Alcohol

Was the person confined to a rehabilitation facility? ☐ Yes ☐ No

If "yes", provide date(s): From _____ To _____

c. **Nervous, behavioral or mental disorders** such as but not limited to anxiety, depression or bipolar disorder?

If "yes", who? _____ ☐ Yes ☐ No

What is the diagnosis? _____

If "yes", select the treatment: ☐ inpatient ☐ prescription medication ☐ counseling

Still under treatment? ☐ Yes ☐ No If "no", when did treatement end? _____ *Date*

d. Been advised to have **diagnostic tests, surgery or hospitalization** in the next 12 months? ☐ Yes ☐ No

If "yes", who? _____ For what reason? _____

e. Received **disability benefits, compensation, or pension** because of illness or injury? ☐ Yes ☐ No

If "yes", who? ☐ Yes ☐ No

What is the nature of the disability? _____

Still disabled? ☐ Yes ☐ No If "no", when was the date of recovery? _____ *Date*

f. Consulted a physician, psychotherapist, counselor or other provider for medical or surgical treatment or advice for any condition not listed above? ☐ Yes ☐ No

If "yes", who? _____ Please give details: _____

g. Had more than $5,000 in medical services in the last 12 months? ☐ Yes ☐ No

If "yes", who? Please give details:

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Health Questionnaire

Section 2- MEDICAL HISTORY DETAILS

1. Please list all prescription medications used in the past 12 months. If you need more space, please attach additional documentation to this application.

Person's Name	Name of and Reason for Medication	Dosage and Frequency of use	Use Began	Use Ended

2. Medical History details for all **"yes"** answers in Section 1- Health Questions/Medical Information. If you need more space, please attach additional documentation to this application.

Person's Name	Diagnosis/Condition/ Treatment	Date of diagnosis	Current Status	Complete recovery?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

Sentara® Health Plans

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Health Questionnaire

Section 3- 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 Sentara Health Plans 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 Sentara Health Plans 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, or a request for change in benefits, this authorization shall be valid for thirty (30) months from the date shown below.

I understand that I may be contacted by Sentara Health Plans 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 Sentara Health Plans. 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 Sentara Health Plans HMO. I understand that it is my responsibility to report to Sentara Health Plans 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:** *(mm/dd/yyyy)*	Daytime Phone:

Print Form **Save Form**

Reset/Clear Form

Additional Notices

Receive wellness reminders and other important information.

By providing your phone number, you are consenting to Sentara Health Plans and its representatives contacting you at any phone number you have provided to us, which may include mobile phone numbers. You understand that you are not required to agree, and agreeing is not a condition of being an Sentara Health Plans member or receiving health care. Communications directed to these phone numbers may be carried out using automated dialing/delivery devices, direct dial, text message, SMS or RCS messages, ringless voicemail, and prerecorded or artificial voices. Communications may include, but may not be limited to, information regarding medication, wellness, preventive care, health plan enrollment, communication preferences, payment, and other information Sentara Health Plans or its representatives believe may interest or be relevant to you. Communications and their content, which may include health information, will not be encrypted. You may revoke this consent at any time. To opt out of phone calls, call 1-800-275-3755. To opt out of text messages, text STOP to short code 59270 or call 1-800-275-3755. If you are not the subscriber to the phone number you provided, then you agree that you have obtained the subscriber's consent to receive these communications. Sentara Health Plans will not charge you for these communications. Carrier messages and data rates may apply.

Need help in another language? Call us.

需要以其他语言获得帮助？ 联系我们。

다른 언어로 도움이 필요하십니까? 저희에게 연락 해 주세요.

Quý vị cần được giúp đỡ bằng một ngôn ngữ khác? Hãy gọi cho chúng tôi.

Kailangan ng tulong sa ibang wika? Tawagan kami.

¿Necesita ayuda en algún otro idioma? Llámenos.

Saad łahgo át'éhígíí daa ts'í bee shíká a'doowoł nínízin. Nihich'į' hólne'.

1-855-687-6260