Sentara Health Plans

Sentara Health Insurance Company and Sentara Health Plans Enrollment Application

1300 Sentara Park
Virginia Beach, VA 23464
(757) 552-7401

☐ **Sentara Health Plans** ☐ **Sentara Health Insurance Company**

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

If you are enrolling your spouse, Domestic Partner, or your children, read this first!

The following situations require that you provide additional information or documentation so that your spouse, Domestic Partner, or your children up to age 26 can be enrolled in your health plan. Without this information your enrollment and I.D. cards may be delayed.

Coordination of Benefits

Complete Coordination of Benefits Information Page only if you or any of your enrolling family members will have medical coverage in addition to the Sentara Plan (check "Yes" for Section 8 - Additional Coverage).

Continuation of Coverage for Children with an intellectual or physical disability:

Children over age 26 with an intellectual or physical disability may continue to be eligible for coverage. You may contact Member Services for this form or for additional information.

Check your application carefully to be sure all birthdays and Social Security numbers are correct.

Please make sure to include birth dates and Social Security numbers for each person who will be covered under the Plan.

Sentara Health Plans

Clear Form

Sentara Health Insurance Company and Sentara Health Plans
1300 Sentara Park
Virginia Beach, VA 23464
(757) 552-7401 (877) 552-7401

Coordination of Benefits Information Page

* Please retain a copy of this coordination of benefits page for your records.

Applicant's Name: _____ Soc. Sec. #: _____

Date of Birth: _____

NOTE: Complete section 1 and section 3 if you have additional commercial insurance.
Complete section 2 and section 3 if you have Medicare.

SECTION 1 (Commercial Insurance)

Name of other Health Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____ Effective Date: _____

Employer: _____

Group Number: _____

Policyholder's Name: _____

Birthdate: _____

List family members covered by this insurance: _____

SECTION 2 (Medicare Information)

Applicant: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

Spouse: _____ Claim#: _____

Domestic Partner: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Is your spouse retired: Yes ☐ No ☐ Retirement date: _____

Is your Domestic Partner retired: Yes ☐ No ☐ Retirement date: _____

SECTION 3

I hereby certify that except as reported above, no service or payments are provided or are recoverable through any other group health insurance or group health service plan.

	Date:

Sentara Health Plans

FOR PLAN USE ONLY

Subscriber #: _____

Date:

Sentara Health Plans and Sentara Health Insurance Company
Large Group (Combined) Enrollment Application

IMPORTANT: Incomplete information will delay enrollment. Please use a ball point pen, press firmly and print clearly.

Section 4

To be completed by employer Group No. _____ **Required** Sub Group No. _____ **Required, if applicable**

◯ **NEW** ◯ **Open Enrollment** ◯ **Continuation of Coverage** ◯ **C.O.B.R.A.** ◯ **PCP or Address Change**

◯ **Cancel All** ◯ **Add Spouse, Dependent, Domestic Partner** ◯ **Cancel Spouse, Dependent, Domestic Partner** ◯ **Reinstatement**

Employer Name	Effective/Termination Date	Employee's Social Security No.	Hire Date

Section 5

Sentara Health Plans Selection: HMO/POS Products Underwritten by Sentara Health Plans			**Sentara Health Insurance Company Plan Selection:** PPO Products Underwritten by Sentara Health Insurance Company
☐ Vantage (HMO)	☐ POS	☐ Vantage POSA	☐ Plus (PPO)
☐ Vantage HSA(HMO)	☐ POS HSA	☐ POSA HSA	☐ Plus HSA(PPO)
☐ Vantage Design (HMO)	☐ POS Design	☐ POSA Design	☐ Plus Design (PPO)

Enter Plan Name: _____

Section 6

TO BE COMPLETED BY EMPLOYEE- **(PLEASE PRINT LEGAL NAME)**

Last Name: _____ First Name: _____ Middle Init. _____

Date of Birth: _____ **MO/DAY/YR** Gender: _____ Primary Care Physician & ID #: **Dr.** _____ Current Patient?

Address: _____ Primary Language: _____

City/State/Zip: _____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____

☐ Mobile ☐ Home ☐ Work ☐ Mobile ☐ Home ☐ Work

Section 7

→ **NOTE: Complete this section only if you have selected a HSAplan in Section 5**

Health Savings Account (HSA) Administration- If you have chosen the HSA eligible high deductible plan offered through your employer, you are eligible to establish a Health Savings Account (HSA). HealthEquity is Sentara's preferred vendor for HSA account administration.

Do you want to establish a HSA account? Effective Date: _____

☐ Yes, please DO establish or continue my existing health savings account for me with HealthEquity.

☐ No, please DO NOT establish a health savings account for me with HealthEquity.

Section 8

Additional Coverage- REQUIRED INFORMATION TO BE COMPLETED BY EMPLOYEE FOR ALL PERSONS LISTED BELOW.

Will any of the persons listed below have any other medical health insurance in addition to Sentara when this coverage takes effect?

◯ Yes ◯ No

If Yes, please complete Sections 1, 2, and 3 on the Coordination of Benefits form attached. If you have other health coverage and have elected a Health Savings Account (HSA), consult your tax advisor on your eligibility for contributing to an HSA.

Section 9

Communications- Please check the boxes below for your preference in receiving communications from Sentara.

Go Paperless! Consent to Receive Electronic Communications

Email Address: _____

By providing your email address above, you agree to receive email communications that <Sentara Health Plans> or its representatives believe may interest or be relevant to you. You may unsubscribe at any time.

☐ **I CONSENT**

By marking the "I CONSENT" checkbox above, you agree to enroll in our Paperless Program and to accept electronic communications at the email you provided from <Sentara Health Plans> or its representatives. You also consent to receive electronic notice that health plan documents and notices are being provided, and are available to view or download, through the <Sentara Health Plans> secure website at <**sentarahealthplans.com/signin**> or on the <Sentara Health Plans> mobile app instead of paper documents through personal delivery or the U.S. Mail. Documents and notices include, but are not limited to, the following: Certificate of Insurance or Evidence of Coverage, Summary Plan Description (SPD), Summary of Material Modification, Uniform Summary of Benefits and Coverages (SBCs), Explanation of Benefits (EOB) and other claim notices; Provider Termination Continuity of Care notices, Medicare Part D notices, and COBRA notices.

Not all documents will be available electronically in the Go Paperless program. If a document or notice is not available electronically we will provide you paper copies. You do not have to enroll in our paperless program to enroll in the health plan. You may revoke your consent to receive electronic communications or request a paper copy of any document free of charge at any time.

Please be aware that certain of the messages sent by Sentara may be unencrypted and that e-mail communication can be intercepted in transmission or misdirected. Please consider communicating any sensitive information by telephone, fax, or mail and take care to protect your devices and messages. By opting into the Go Paperless program, you agree to receive electronic communications, even if they are sent in an unencrypted format.

Phone Number and Consent:

Phone Number: _____

☐ **I CONSENT**

By providing your phone number and clicking the "I CONSENT" button above, you consent to allow <Sentara Health Plans> and its representatives to contact you at any phone number you have provided to us, including mobile phone numbers. You understand that you are not required to agree and agreeing is not a condition of being a <Sentara Health Plans> 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 Health Plans>, reminders to renew before your plan expires, 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. Content contained within these communications, which may include health information, will not be encrypted. <Sentara Health Plans> 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, you may sign in to the <Sentara Health Plans> website at <**sentarahealthplans.com/signin**>, use the <Sentara Health Plans> mobile app, or call Member Services at <**1-866-514-5916**>. To opt out of text messages, text STOP to short code <**59270**>, sign in to the <Sentara Health Plans> website at <**sentarahealthplans.com/signin**>, use the <Sentara Health Plans> mobile app, or call <**1-866-514-5916**>.

Section 10

Please list below all dependents to be covered by the enrollment application.

Social Security No.		Last Name	First Name, MI	Date of Birth MO/DAY/YR	M/F	Primary Care Physician & ID # (not needed for Plus (PPO) plans)	Current Patient
	SPOUSE			/ /		DR.	
	DOMESTIC PARTNER			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	

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

Section 11 AUTHORIZATION

I am applying for Sentara coverage for myself and the family members listed. I agree that once enrolled I and my family members will abide by the provisions of coverage in the Group Contract and Evidence of Coverage or Certificate of Insurance under which we will be enrolled. Sentara is the trade name for several different companies including Sentara Health Plans and Sentara Health Insurance Company.

I understand that misrepresentation in answering questions on this application or non-payment of premiums may result in loss of coverage under the Group Health Plan.

I understand that Sentara may receive and collect personal information from persons other than me. The collected personal or privileged information may be disclosed to third parties without authorization. I understand that I have a right to access and correct all personal information collected about me. I understand that I will receive upon request Sentara's complete notice of information collection and disclosure practices.

I authorize any physician, hospital, pharmacy, or other provider of health services or supplies, to disclose to Sentara medical and other information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. This authorization shall extend to representatives of Sentara as needed to fulfill the purposes of the disclosure. I also give Sentara the right to receive from, and release information to, other insurance companies as needed to administer coordination of benefits (COB) provisions under the Group Policy or Group Agreement.

I understand that Sentara, upon receiving information, may use it to evaluate eligibility for coverage, a claim for benefits, a request for change in policy benefits, or administer COB. 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.

Any information received by Sentara 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 and agree that no benefits shall take effect until this application is received and processed by Sentara and a Sentara ID card with an effective date of coverage has been provided.

I understand that it is my responsibility to report and verify to Sentara any change in the eligibility of myself or my covered family members. If requested, I agree to supply acceptable documentation. I also understand that I am obligated to pay applicable copayments, coinsurance or deductibles at the time services are rendered.

I certify that I have maintained a copy of this completed application for my records. I understand that this application shall become a part of the Group Contract. I further understand that I or my authorized representative may receive a copy of this application upon request. I agree that a photographic copy of this authorization 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.

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____