OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401

Optima Health Insurance Company and Optima Health Plan Enrollment Application

☐ **Optima Health Plan** ☐ **Optima 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 Optima Health plan (check "Yes" for Section 8 - Additional Coverage).

Continuation of Coverage for Children with an Intellectual Disability or Physical Handicap:

Children over age 26 with an intellectual disability or physical handicap 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.

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Clear Form

Optima Health Insurance Company
and Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462
(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:

OptimaHealth

FOR PLAN USE ONLY

Subscriber #: _____

Date:

Optima Health Plan and Optima 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

Optima Health Plan Selection: HMO/POS Products Underwritten by Optima Health Plan			**Optima Health Insurance Company Plan Selection:** PPO Products Underwritten by Optima Health Insurance Company
☐ Vantage (HMO)	☐ POS	☐ Vantage POSA	☐ Plus (PPO)
☐ Equity Vantage (HMO)	☐ Equity POS	☐ Equity POSA	☐ Equity Plus (PPO)
☐ Design Vantage (HMO)	☐ Design POS	☐ Design POSA	☐ Design Plus (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 an Equity plan in Section 5

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? 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 Optima Health Plan 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 Optima Health.

Go Paperless!

Please check the box below to enroll in our Paperless Program and consent to receive electronic communications from Optima Health. By enrolling in our Paperless Program, you are consenting to receive email communication and, upon enrollment, electronically receiving policy documents through your secure Optima online portal account or app, rather than in paper form through personal delivery or the U.S. Mail.

Email Address: _____

☐ I agree to accept electronic communications notifying me of important health plan information, including but not limited to, the Certificate of Insurance, Evidence of Coverage, plan updates and Uniform Summary of Benefits documents.

Receive wellness reminders and other important information

By providing your phone number, you are consenting to Optima Health 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 Optima Health 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, push notifications, 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 Optima Health 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 1-800-741-9910. To opt out of text messages, text STOP to short code 59270 or call 1-800-741-9910. 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. Optima Health will not charge you for these communications. Carrier message and data rates may apply.

Section 10 Please list below all dependents to be covered by the enrollment application.

(not needed for Plus (PPO) plans)

Social Security No.		Last Name	First Name, MI	Date of Birth MO/DAY/YR	M/F	Primary Care Physician & ID #	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

Receive reminders to renew before your plan expires next year

By providing your phone number, you are consenting to Optima Health 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 Optima Health 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, push notifications and prerecorded or artificial voices. Communications may include, but may not be limited to marketing messages to promote Optima Health's products and services and renewal reminders. You may revoke this consent at any time. To opt out of phone calls, call 1-800-741-9910. To opt out of text messages, text STOP to short code 59270 or call 1-800-741-9910. 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. Optima Health will not charge you for these communications. Carrier message and data rates may apply.

Signature of Applicant _____ Date _____

I am applying for Optima Health 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. Optima Health is the trade name for several different companies including Optima Health Plan and Optima 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 Optima Health 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 Optima Health'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 Optima Health 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 Optima Health as needed to fulfill the purposes of the disclosure. I also give Optima Health 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 Optima Health, 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 Optima Health 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 Optima Health and an Optima Health ID card with an effective date of coverage has been provided.

I understand that it is my responsibility to report and verify to Optima Health 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 _____