OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

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FOR PLAN USE ONLY
Subscriber #:
Date:

Optima Health Plan and Optima Health Insurance Company Enrollment Application and Waiver Mid-Market 51-150 Coordination of Benefits

Optima Health Plan Selection:
HMO/POS Products Underwritten by Optima Health Plan

- ☐ Vantage *(HMO)*
- ☐ Equity Vantage *(HMO)*
- ☐ Design Vantage *(HMO)*
- ☐ POS/POSA *(HMO)*
- ☐ Equity POS/ POSA *(HMO)*
- ☐ Design POS/ POSA *(HMO)*
- ☐ Vantage Direct *(HMO)*
- ☐ POS Direct *(HMO)*
- ☐ Equity Vantage Direct *(HMO)*
- ☐ Equity POS Direct *(HMO)*
- ☐ Vantage Select *(HMO)*
- ☐ POS/POSA Select *(HMO)*
- ☐ Design Vantage Select *(HMO)*

Optima Health Insurance Company Plan Selection:
PPO Products Underwritten by Optima Health Insurance Company

- ☐ Plus *(PPO)*
- ☐ Out-of-Area Plus *(OOAPPO)*
- ☐ Design Plus *(PPO)*
- ☐ Out-of-Area Design Plus *(OOAPPO)*
- ☐ Equity Plus *(PPO)*
- ☐ Out-of-Area Equity Plus *(OOAPPO)*

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, **supporting documentation may be required.**

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)

Use Alternate Mailing Address for this member? ☐ Yes ☐ No

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

OptimaHealth

Subscriber Name:
Employer Name:

B. EMPLOYEE INFORMATION *(continued)*

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.

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 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 Optima Health'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.

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

☐ **No**, I already have a health savings account established with Health Equity.

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:*

OptimaHealth

Subscriber Name:
Employer Name:

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/POSA), 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

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

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

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

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Subscriber Name:
Employer Name:

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

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 have more than four (**4**) dependents please reprint this page and continue to fill out the information requested for all eligible dependents.*

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:

OptimaHealth

Subscriber Name:
Employer Name:

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 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 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 Insurance Company or Optima Health Plan 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)*

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Optima Health Alternative Language Options for Notices and other Written Information

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-687-6260.

Amharic:
ማሳሰቢያ፡
አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ከክፍያ ነጻ የሆነ የቋንቋ እገዛ አገልግሎት ይቀርብልዎታል። በዚህ ስልክ ይደውሉ 1-855-687-6260።

Arabic:

تنبيه:
إذا كنت تتحدث باللغة العربية، فإنه تتوفر خدمات المساعدة اللغوية لك مجانًا. اتصل بالرقم 1-855-687-6260.

Bengali/Bangla:
লক্ষ্য করবেনঃ যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়ক পরিষেবাও পাবেন। ফোন করুন– 1-855-687-6260।

Chinese (Mandarin):
注意：如果您讲中文普通话，可以免费获得语言协助服务。请拨打电话 1-855-687-6260。

French:
ATTENTION : Si vous parlez français, les services d'assistance linguistique sont à votre disposition sans aucun frais. Appelez le 1-855-687-6260.

German:
ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen Sprachhilfsdienste kostenlos unter der Rufnummer 1-855-687-6260 zur Verfügung.

Gujarati:
ધ્યાન આપો : જો તમે ગુજરાતી બોલી છો તો ભાષા સહાયક સેવાઓ તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-687-6260 પર કૉલ કરો.

Hindi:
ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-687-6260 पर कॉल करें।

Hmong:
CIM CIA: Yog tias koj hais lus Hmoob, kev pab cuam txais lus tau muaj rau koj ua tsis them nqi. Hu rau 1-855-687-6260.

Igbo:
GEE NT Ị: ọbụrụ na ị na-asụ Igbo, ị ga-enweta enyemaka n'efu site n'aka ndị ga-enyere gi aka inweta ya. Kpọọ 1-855-687-6260

Japanese:
重要：日本語を話される場合、無料の言語支援サービスがご利用いただけます。1-855-687-6260までお電話ください。

Korean:
주의: 한국어를 사용하실 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-6260번으로 전화해 주십시오.

Kru/Bassa:
YI LE: I bale u mpot Bassa, bot ba kobol mahop ngui nsaa wogui wo ba ye ha I nyuu hola we. Sebel: 1-855- 687-6260.

Laotian:
ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ນໍາໃຊ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-687-6260.

Mon-Khmer, Cambodian:
កំណត់សំគាល់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មផ្នែកជំនួយការភាសា មានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ចូរហៅទូរស័ព្ទទៅកាន់ 1-855-687-6260។

Navajo:
SHOOH: Diné Bizaad bee yáníłti'go doo bą́ą́h ílínígóó t'áá nizaad k'ehjí níká a'doowołgo bee haz'ą́. Kojį' hólne' 1-855-687-6260.

Persian/Farsi:
توجه:
اگر به زبان فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شماست. با شماره 1-855-687-6260 تماس بگیرید.

Portuguese:
ATENÇÃO: Se você fala português, há serviços de assistência em idiomas disponíveis para você gratuitamente. Ligue para 1-855-687-6260.

Russian:
ВНИМАНИЕ! Если вы говорите на русском языке, позвоните по телефону 1-855-687-6260, и наша служба языковой поддержки окажет вам бесплатную помощь.

Spanish:
ATENCIÓN: Si habla español, existen servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-687-6260.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-855-687-6260.

Turkish:
DİKKAT: Eğer Türk konuşuyorsanız, dil asistanı servislerini ücretsiz olarak kullanabilirsiniz. 1-855-687-6260 numaralı telefonu arayın.

Urdu:
توجہ دیں:
اگر آپ اُردو زبان بولتے ہیں تو، زبان کی معاونتی خدمات، بغیر کسی خرچ کے، آپ کے لئے دستیاب ہیں۔ 1-855-687-6260 کال کریں۔

Vietnamese:
CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Hãy gọi 1-855-687-6260.

Yoruba:
KÉÉRE:
Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Pe 1-855-687-6260