

Sentara Standard Gold 2000 Ded

1300 Sentara Park Virginia Beach, VA 23464

FOR PLAN USE ONLY
Subscriber #:
Date:

# **Sentara Health Plans** | Sentara Standard **Application for Individual Health Coverage**

☐ New Applicant		☐ Cha	Change/modification of existing policy											
Effective Date:		Memb	er Nam	e: _										
		Memb	er Num	ber: _										
<ul> <li>MPORTANT:</li> <li>This health plan is offered and underwritten by Sentara Health Plans. In this document we may use the term Sentara to refer to this plan.</li> <li>Incomplete information will delay enrollment. Please complete all sections in blue or black ink.</li> <li>Social Security numbers are to be provided for the primary subscriber, spouse and dependent child(ren) covered by this plan.</li> <li>If you are adding or removing a spouse or dependent, please attach supporting documentation within 60 days from the triggering event. Examples include a marriage or birth certificate, adoption papers, etc.</li> <li>Please note that this application is not valid if your intent is to enroll on a plan that is offered on the Health Insurance Marketplace. For those plans, please visit www.healthcare.gov/marketplace/individual.</li> </ul>														
Pediatric Oral Health Benefits: This policy does not provide the ACA-required minimum essential pediatric oral health benefits. Stand-alone dental coverage that includes such benefits must be available to you for purchase separately from a qualified stand-alone dental plan.														
A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT (Check all that apply)														
Change/Correction:  Telephone Change		Name Cha	Ū	□ of Birth (	Plan R Correcti	einstate on	ment		Addre:		hange ress		Plan Cha	inge
Date of Qualifying Event: (m.	m/dd/	уууу)												
Add Dependent(s)		Marriage Other: Pl	ease no	New ote:	born		Adopt	ion		Lo	ss of Co	verag	ge	
Remove Dependent(s)		Marriage Other: Pl		Divorcote:	e	□ Me	edicare		Death	1		ige O	out (26 ar	nd 65)
B. PLAN SELECTION- I	POLI	CY DEDI	UCTIB	LE ar	nd/or (	COINS	URAN	ICE						
			S	entara	a Heal	th Plai	าร			-				
				Sentar	a Plan	Options	5							
☐ Sentara Platinum 0 Ded		Sentara G	Gold 350	00 Ded		Sentara	a Silver	5000	Ded		Sentara	Bron	nze 7200	Ded
☐ Sentara Gold 1000 Ded		Sentara S	Silver 32	200 Dec		Sentara	a Silver	5900	Ded		Sentara	Bror	nze 8400	Ded
☐ Sentara Gold 1300 Ded☐ Sentara Gold 2200 Ded☐		Sentara S Ded HSA Sentara S				Sentara Sentara Ded HS	a Bronz				Sentara	Bron	nze 9800	Ded

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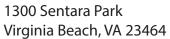
Sentara Standard Plan Options

☐ Sentara Standard Bronze 7500 Ded

 $\hfill \square$  Sentara Standard Silver 6000 Ded



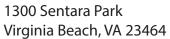
C. PRIMARY APPLICANT INFO			INT LEGAL NAM						
<ul> <li>If this is a child only applic birth, relationship to child information should be incl</li> </ul>	cation, please and primary luded under t	e include ti phone nur he Child 1	ne Parent/Gua nber in this so section on pa	ardian na ection. T age 3.	ame, The c	add hild	ress, dat only app	e of licar	nt
Last Name:		First Name:	-				Middle	Initial:	
Home Address: (no P.O. Box)		1.							
City:			State:	Z	ір Со	de:			
Social Security Number:	Date of Birtl	n: (mm/dd/yyyy)	U.S. Citizen:		Yes No	Disabled:		Yes No	
Gender:	Primary Phone:   Mobile  Ho	omo □ Work			ndary obile	Phon		rle	
Mailing Address: (If different from hon			y:	State		□ ⊓0	Zip C		
Go Paperless! Consent to Receive	e Electronic Cor	nmunication	s						
Email Address:									
By providing your email address above, believe may interest or be relevant to yo				entara Heal	th Plai	ns> or	its represent	atives	
I CONSENT									
By marking the "I CONSENT" checkbox the email you provided from <sentara <sentarahealthplans.com="" and="" are="" being="" documents="" h="" notices="" provid="" signin=""> or or the U.S. Mail. Documents and notice Summary Plan Description (SPD), Summand Benefits (EOB) and other claim notices;  Not all documents will be available elect provide you paper copies. You do not have receive electronic communications or replease be aware that certain messages transmission or misdirected. Please con your devices and messages. By opting sent in an unencrypted format.</sentara>	lealth Plans> or its led, and are available, and are available in the <sentara a="" and="" are="" but="" by="" communication.<="" copy="" enroll="" golave="" he="" in="" include,="" is="" marchine="" material="" musider="" of="" our="" paper="" provider="" quest="" reary="" sent="" sentara="" termination="" th="" the="" to=""><th>representative ble to view or dealth Plans&gt; monot limited to, the odification, Union Continuity of Paperless prograperless prograper any documinary be unencrying any sensitive.</th><th>s. You also consent ownload, through the bile app instead of the following: Certification Summary of Early Care notices, Medigram. If a document am to enroll in the ent free of charge apted and that e-maite information by tel</th><th>t to receive he <sentar and="" any="" at="" communication,="" dicare="" doctocate="" faither="" health="" i="" in="" insu="" notice="" of="" paper="" part="" penefits="" plar="" s<="" sentation="" th="" the="" time.="" tor=""><th>electronal Heal uments urance I Cove D noti s not a n. You cation x, or m</th><th>onic no th Plar s throu or Evi rages ( ces, ar available may re can be</th><th>otice that heans hear hear hear hear hear hear hear hear</th><th>Ith pla Portal deliver verage anatio otices. ally we onsent in o prote</th><th>n at ry e, n of will to</th></sentar></th></sentara>	representative ble to view or dealth Plans> monot limited to, the odification, Union Continuity of Paperless prograperless prograper any documinary be unencrying any sensitive.	s. You also consent ownload, through the bile app instead of the following: Certification Summary of Early Care notices, Medigram. If a document am to enroll in the ent free of charge apted and that e-maite information by tel	t to receive he <sentar and="" any="" at="" communication,="" dicare="" doctocate="" faither="" health="" i="" in="" insu="" notice="" of="" paper="" part="" penefits="" plar="" s<="" sentation="" th="" the="" time.="" tor=""><th>electronal Heal uments urance I Cove D noti s not a n. You cation x, or m</th><th>onic no th Plar s throu or Evi rages ( ces, ar available may re can be</th><th>otice that heans hear hear hear hear hear hear hear hear</th><th>Ith pla Portal deliver verage anatio otices. ally we onsent in o prote</th><th>n at ry e, n of will to</th></sentar>	electronal Heal uments urance I Cove D noti s not a n. You cation x, or m	onic no th Plar s throu or Evi rages ( ces, ar available may re can be	otice that heans hear hear hear hear hear hear hear hear	Ith pla Portal deliver verage anatio otices. ally we onsent in o prote	n at ry e, n of will to
Phone Number and Consent:									
Phone Number:									
I CONSENT									
You can choose to receive messages at reminders, and other information Sentar marketing messages to promote product	a or its representat	tives believe m	ay interest or be re						
By selecting the checkbox for "I Consent phone number you have provided to us, then you agree that you have obtained to phone numbers may be conducted using voicemail, push notifications, and prerectinformation, will not be encrypted. Sentate communications to receive health care of	including mobile p the subscriber's cong g automated dialing corded or artificial v ara will not charge y	hone numbers nsent to receiv g/delivery devid oices. Content you for these c	. If you are not the set these communicates, direct dial, text contained within the mmunications and	subscriber itions. Con message, lese commi lyou are no	to the nmunic SMS c unicati ot requ	phone cations or RCS ons, w ired to	number you directed to to messages, r hich may inc	provid hese ingles lude h	ed, s ealth
You may revoke your consent at any tim Member Portal ( <b>sentarahealthplans.co</b>									ard.





Primary Care Physician: (PCP) If applying for Sentara Health Plans the Plan's Provider Directory for ea			anization	(HMO) pleas	se selec	t a pri	mary car	e phy	sician fro	m
PCP Last Name:	,		PCP Fire	st Name:						
Provider Number: (If known)					Cu	rrent F	atient?		Yes 🗆	No
Parent/Guardian Information (i	if child only applica	ation)	Relation	ship to Child	d: 🗆	Pai	ent		Guard	lian
Parent/Guardian Last Name:		Parent/	'Guardiar	n First Name:			Date of	Birth:	(mm/dd/y	ууу)
Home Address: (no P.O. Box)			City:		State	) <i>:</i>	ı	Zip	Code:	
D. HEALTH SAVINGS ACCOUN	NT (if applicable	e)								
Health Savings Account (HSA) Admi establish a Health Savings Account (HS				ferred vendor	for HS/ Effectiv	A adm e date	nistratior :		are eligibl	e to
Do you want to establish a HSA?					(mm/da	,				
<ul><li>☐ Yes, please DO establish or o</li><li>☐ No, please DO NOT establish</li></ul>	•	-	•			Healt	nEquity.			
E. INDIVIDUAL COVERAGE I						NT (	CHRA	)		
Is anyone listed on the application offer										
☐ If <b>YES</b> , then please provide the				employer:		_	-			
☐ If <b>NO</b> , skip to Section F	o remedining innerma		Jame of	CHRA admin	istrator					
F. ALTERNATE MAILING ADDR	DEGG	•	101110 01	Or in a radinini	iotrator					
If your spouse or any depend		ve nlan	informat	ion to an add	dress c	ther t	nan that	listed	under	
Section C Primary Appli	icant Information, <sub>I</sub>	please p								
Applicable Member: Al	Iternate Mailing Ad	ldress:		City:		St	ate:		Zip C	ode:
<ul> <li>For additional addresses, ple</li> </ul>	ease reprint this	page	and co	ntinue to fill	out fo	r add	itional p	olicv	membe	ers.
G. FAMILY INFORMATION								'		
<ul> <li>Please complete only if your sp</li> <li>If enrolling dependents, how many</li> </ul>		<u>epenae</u>	<u>nt cniia</u>	<u>ren are app</u>	<u>iying 1</u>	or co	<u>verage.</u>			
SPOUSE	ncel Use Alterna	ate Mail	ina Addr	ess for this m	nember	?	□ Y	es		No
Last Name:		irst Nar							ldle Initial	
Social Security Number:	[	Date of I	Birth: <i>(mi</i>	n/dd/yyyy)	U.S Citizer	5. <b>-</b>	Yes Di	<u>l</u> isable	ed: $\square$	Yes No
	Primary Phone:						Phone:			INO
Gender:	Email Address:									
☐ Female										
NOTE: Primary Care Physician please select a primary care physician								Orgar	nization (I	HMO)
PCP Last Name:			PCP Fire	st Name:		1				
Provider Number: (If known)					Curr	ent Pa	tient?		Yes 🗆	l No
CITUD ADD 260TF										3

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G. FAMILY INFORMATION (continued)		
CHILD 1 ☐ Add ☐ Cancel Use Alter	nate Mailing Address for this m	ember? □ Yes □ No
Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: (mm/dd/yyyy)	U.S.  Yes Disabled: Yes
Drives m. Dh. s.m.s.		Citizen: U No U No
☐ Male Primary Phone:		Secondary Phone:
Gender:     Female   Email Address:		'
Primary Care Physician (PCP): (If needed)		
PCP Last Name:	PCP First Name:	
Provider Number: (If known)		Current Patient? ☐ Yes ☐ No
-		
CHILD 2	nate Mailing Address for this m	
Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth: (mm/dd/yyyy)	
Social Security Number.	Date of Biltil. (Illillillidd/yyyy)	U.S.  Yes Disabled: No
Primary Phone:		Secondary Phone:
☐ Male		
Gender: Email Address:		
Primary Care Physician (PCP): (If needed)		
PCP Last Name:	PCP First Name:	
Provider Number: (If known)		
Flovider Nulliber. (II Khown)		Current Patient?
CHILD 3	nate Mailing Address for this n	nember?
CHILD 3 ☐ Add ☐ Cancel Use Alter Last Name:	First Name:	nember?
Last Name.	riist name.	iviladie mitiai.
Social Security Number:	Date of Birth: (mm/dd/yyyy)	U.S.  Yes Yes
,,		Citizen: No Disabled: No
☐ Male Primary Phone:		Secondary Phone:
Gender: Email Address:		
☐ Female Email Address.		
Primary Care Physician (PCP): (If needed)		
PCP Last Name:	PCP First Name:	
Provider Number: (If known)		
Tovidor Hambor. (ii Anown)		Current Patient?
<ul> <li>If you have more than three (3) dependent</li> </ul>	's please reprint this page	and continue to fill out the
<ul> <li>If you have more than three (3) dependent information requested for all eligible dependent</li> </ul>	idents.	

Date

5



Enrollee Signature

H. RACE,	ETHNICITY (This inform	nation is voluntary.)			
not have to p	provide this information to red	n plan members to voluntarily pro- ceive covered services under you on is kept strictly confidential and	r health plan. We	ask for this i	nformation to help us
Race White/Caucasian Black or African American American Indian or Alaska Native Asian Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian  Native Hawaiian or Other Pacific Islander Native Hawaiian Guamanian or Chamorro Other Pacific Islander Middle Eastern or North African Another Race Not Listed Above Decline to Report Unknown  Vietnamese Other Asian			n	Chicano/a Puerto Rica	exican American, in v Not Listed Above
	Last Name	First Name	Race		Ethnicity
Enrollee					
Spouse					
Domestic Partner					
Dependent					
		1	<u> </u>	,	l



I. OTHER COVERAGE INFORMATION (	(Required before enrollment ca	an 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 I.  ☐ Yes If YES, then please provide the following information about that coverage.							
nsured Person (Name): Identification (Policy) No.							
Effective Date: (mm/dd/yyyy)	Name of employer or organiza	tion 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 o	complete the information requested.					
Covered Person: (Name)		HIC Number:					
Effective Date: Part A (mm/dd/yyyy)	Effective	e Date: Part B (mm/dd/yyyy)					
Eligible due to:	´ <b>-</b>	5 or over					
Month/Year: Month/Year:							
<ul> <li>If you have a family member who is enrolled on more than one additional health plan, please reprint this page and continue to fill out the additional coverage information for any coverage that will be active in addition to the plan you are applying for.</li> </ul>							

## Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

I confirm that I have read this replacement notice and have checked and/or initialed one of the following regarding my application:

- ☐ This application is for coverage under a Sentara Health Plans Individual policy which if issued <u>will not replace other</u> <u>coverage presently in force</u>.
- This application is for coverage under a Sentara Health Plans Individual policy which if issued <u>will replace other</u> <u>coverage presently in force</u>. Please read the following additional information regarding replacement coverage:

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Sentara Health Plans. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.



J. INITIAL PAYMENT INFORMATION- P	lease select one pa	nyment type				
CREDIT CARD / DEBIT CARD						
If paying by credit card or debit card, ple from Sentara with instructions on how to	ease wait to receive e o make payment.	either your welcome le	tter or initial invoice			
AUTOMATIC BANK DEDUCTION						
Banking Information						
If your banking information is different please fill out the next page and p						
Bank Routing Number:	Bank Accour	Bank Account Number:				
Primary Name on Bank Account:	<u> </u>					
Name of Financial Institution:		Branch Phone Numb	er:			
Branch Address:	City:	State:	Zip:			
CHECK, MONEY ORDER, OR CASHIEF	RS CHECK	, ,	·			
To ensure proper posting, please in (if applicable) on Check, Money Or	nclude member name ders, or Cashiers Ch	e, member number, an eck.	d invoice number			
	Mail Payment to Sentara Health Plar 1300 Sentara Park Virginia Beach, VA 23	ns (				
MONEYGRAM						
	remium payments at Mon ng most 7-Eleven, CVS a (No service fees		Virginia,			



K. ON-GOING MONTHLY PAYMENT INFORMAT	K. ON-GOING MONTHLY PAYMENT INFORMATION- Payments Must Be Made Monthly						
AUTOMATIC CREDIT CARD / DEBIT CARD							
Instructions for automatic credit or debit card payments are available on our website, during or after initial payment is made.							
AUTOMATIC BANK DEDUCTION							
Banking Information							
If your banking information is different for yo please fill out the previous page and provide t							
Bank Routing Number:	Bank Account N	umber:					
Primary Name on Bank Account:	•						
Name of Financial Institution:	Branch Phone Number:						
Branch Address:	City:		State:	Zip:			
CHECK, MONEY ORDER, OR CASHIERS CHEC	K			•			
To ensure proper posting, please include me (if applicable) on Check, Money Orders, or C	ember name, m Cashiers Check	nember	number, an	d invoice number			
Mail Payment to: Individual Product PO Box 715892 Philadelphia, PA 19171-5892							
PRE-PAID DEBIT							
Payments with Pre-Paid Debit Cards: Calls must be	made monthly to	(757)687	7-6434 or (88	8)737-5479			
MONEYGRAM							
Make convenient premium pay including most 7-E (No		Walmart l		Virginia,			



#### .. CERTIFICATION AND AUTHORIZATION

## The following section must be signed and dated by the primary applicant.

I understand that no coverage will be in force until Sentara determines eligibility for coverage, and notifies me of the first effective date of coverage. I understand that my enclosed premium will be applied to coverage for eligible person(s); and I understand that the premium will be refunded if no persons are eligible for coverage selected and no other coverage is accepted. I also understand that premiums not paid in accordance with this provision, and the terms of the policy, will result in the non-renewal or discontinuance of the policy issued from this application.

I understand that the policy that I am applying for is an individual health insurance policy, and I understand that the policy, if issued, shall not be used as an employer provided healthcare benefit plan. I certify that no employer of any person covered under this policy may pay any premium for this coverage, directly or indirectly, including through wage adjustment. I understand that "employer" does not include a trade of business wholly owned by an individual or individual and spouse that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

I understand that coverage is not in force until the effective date shown on the Schedule of Benefits 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 Sentara any change in eligibility of myself and my dependents. I agree to provide supporting documentation that is acceptable to Sentara if requested.

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 in reference to my policy and that I will receive upon request Sentara's complete notice of information collection and disclosure practices.

I hereby authorize any provider of health services or any insurance company that has any personal medical records or knowledge of my health or my dependents' health to give to Sentara any such personal medical information for the purposes of administering coordination of benefits provisions and for the payment of claims once enrolled. This Authorization shall extend to representatives of Sentara as needed to fulfill the purposes of the disclosure. 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.



### L. CERTIFICATION AND AUTHORIZATION (continued)

I understand any personal medical 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 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 representative, are entitled to 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 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 I can revoke this Authorization at any time by giving written notice to Sentara Health at 1300 Sentara Park Virginia Beach, VA 23464. 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. 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 for the policy.

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. I further understand that I or my legal representative may receive a copy of this application upon request.

If you or any of your covered dependents are covered by more than one health plan, benefits under your Sentara plan will be coordinated so that the same health care services don't get paid for twice.

I, and my agent (if applicable), hereby certify that I have read, or have had read to me, 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.

The following section must be signed and dated by the primary applicant.							
Signature of Primary Applicant <i>or prii</i> Representative:	nt, sign name, and sp	ecify title of Legal	Date: (mm/dd/yyyy)				
Print Agent name if applicable:			Date: (mm/dd/yyyy)				
Signature of Agent if applicable:			Date: (mm/dd/yyyy)				
Agency Number:	Agent Number:	Receipt D	Pate: (mm/dd/yyyy)				
Primary Phone:		Fax Number:					
Email Address:							

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