Sentara Health Plans

1300 Sentara Park
Virginia Beach, VA 23464

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| FOR PLAN USE ONLY |
|---|
| Subscriber #: |
| Date: |

☐ Sentara Health Plans ☐ Sentara Health Insurance Company

# Enrollment Application and Waiver Mid-Market Coordination of Benefits

## Sentara Plan Selection

| | *HMO/POS Products Underwritten by Sentara Health Plans* | | *PPO Products Underwritten by Sentara Health Insurance Company* |
|---|---|---|---|
| Please Check One: | ☐ Vantage *(HMO)* | ☐ POS/ POSA (POS) | ☐ Plus *(PPO)* |
| Enter Plan Name: _____ | | | |

**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, Domestic Partner, and dependent child(ren) covered by this plan.
- If you are adding a spouse, Domestic Partner, or dependent due to a qualified event, **supporting documentation may be required.**

## A. GROUP INFORMATION *(Required to be completed by Employer)*

☐ New Applicant ☐ ADD Spouse, Dependent, Domestic Partner ☐ Address Change ☐ Name Change

☐ CANCEL ALL ☐ Cancel Spouse, Dependent, Domestic Partner ☐ COBRA *(effective date)*: ☐ PCP Change

| Group Name: | Group Number: | Sub 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: ○ Mobile ○ Home ○ Work | Secondary Phone: ○ Mobile ○ Home ○ Work | Gender: ☐ Female ☐ Male | Disabled: ☐ Yes ☐ No |

**Primary Care Physician: (PCP)**

If applying for Sentara Health Plans Health Maintenance Organization (HMO) or the Point of Service Plan (POS), please select a primary care physician from the Plan's Provider Directory for each family member listed. The Preferred Provider Organization (PPO) and 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 |
|---|---|---|---|

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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.

## 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 spouse only.
- ☐ I decline coverage for my Domestic Partner only.
- ☐ I decline coverage for my children only.
- ☐ I decline coverage for my spouse, Domestic Partner, 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, Equity POS, 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's preferred vendor for HSA account administration.
*Do you want to establish a HSA account?*

- ☐ **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.

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| Subscriber Name: |
|---|
| Employer Name: |

## E. ALTERNATE MAILING ADDRESS

***Employee:*** ☐ *Yes* ☐ *No* ***Spouse, Dependent, Domestic Partner:*** ☐ *Yes* ☐ *No*

If the employee, spouse, domestic partner 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:* |

## F. SPOUSE, Domestic Partner, AND DEPENDENT ENROLLMENT INFORMATION

**NOTE: Primary Care Physician: (PCP)** If applying for the Sentara Health Plans Health Maintenance Organization (HMO) or Point of Service Plan (POS/POSA), please select a primary care physician from the Plan's Provider Directory for each family member listed. The Sentara Health Insurance Company Preferred Provider Organization (PPO) and 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 |

**DOMESTIC PARTNER** ☐ 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 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 |

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|---|
| Employer Name: |

## F. SPOUSE, Domestic Partner AND DEPENDENT ENROLLMENT INFORMATION *(continued)*

**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 |

**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:** ☐ 65 or over ☐ Disability ☐ Working ☐ Retired

☐ End Stage Renal Disease (ESRD) Month/Year:

☐ Disability & Current ESRD Month Year:

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| Subscriber Name: |
| --- |
| Employer Name: |

## H. CERTIFICATION AND AUTHORIZATION

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

I have read, or have had read to me the completed application. I have maintained a copy of the completed application and I realize that any false statements in the application may result in loss of coverage under this policy.

I understand that coverage will be through my employer's health plan. I understand that my employer's application will determine the coverage and that coverage will only be in place if an application for the coverage has been made by my employer. 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 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 is not an insurance agent for the Sentara Health Plans or Sentara Health Insurance Company.

I understand that coverage becomes effective on the 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 I will comply with the requirements in the Group Contract and Evidence of Coverage or Certificate of Insurance issued to my employer when I enroll in my employer's plan.

I understand that it is my responsibility to report to Sentara Health Insurance Company or Sentara Health Plans any changes in my or my dependent's situation, such as a change in jobs, marriage or divorce, or living situation that could affect the eligibility of myself and my dependents for coverage under my employer's health plan. I agree to provide proof of my employment and any other eligibility information that Sentara reasonably requests.

I hereby authorize any provider of health services, or any insurance company that has my personal health records or knowledge of my health or my dependents' health to give Sentara Health Plans or Sentara Health Insurance Company as checked on page one, any such information for the purposes of administering my health benefits and for the payment of claims for me or my dependents who are enrolled under my employer's health plan. 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.

I understand any personal health 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 legal representative, may receive a copy of this Authorization upon request, and I agree that a photographic copy of this Authorization is 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. 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 Plans or Sentara Health Insurance Company at 1300 Sentara Park Virginia Beach, VA 23464. I also understand that if I revoke my Authorization it will not affect the rights of any individual who has acted in reliance on the Authorization prior to receiving notice that I am revoking it.

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.

x

**Signature of Employee** or print, sign name, and specify title of Legal Representative: **Date:** *(mm/dd/yyyy)*