



4417 Corporation Lane  
Virginia Beach, VA 23462

**FOR PLAN USE ONLY**

Subscriber #:

Date:

**Optima Health Plan and Optima Health Insurance Company  
Enrollment Application and Waiver Small Group 1-50  
Coordination of Benefits**

**Optima Health Plan Selection:**

*HMO/POS Products Underwritten by Optima Health Plan*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Vantage (HMO)          | <input type="checkbox"/> Vantage Direct (HMO)        | <input type="checkbox"/> Vantage Select (HMO)        |
| <input type="checkbox"/> Equity Vantage (HMO)   | <input type="checkbox"/> POS Direct (POS)            | <input type="checkbox"/> Equity Vantage Select (HMO) |
| <input type="checkbox"/> POS (POS)              | <input type="checkbox"/> Equity Vantage Direct (HMO) | <input type="checkbox"/> Design POS Direct (POS)     |
| <input type="checkbox"/> Equity POS/ POSA (POS) | <input type="checkbox"/> Equity POS Direct (POS)     |  |

Specific Plan Benefit: \_\_\_\_\_

**Optima Health Insurance Company Plan Selection:**

*PPO Products Underwritten by Optima Health Insurance Company*

- |  |   |
|--|---|
| <input type="checkbox"/> Plus Direct (PPO)         | <input type="checkbox"/> Equity Plus Direct (PPO)         |
| <input type="checkbox"/> Out-of-Area Plus (OOAPPO) | <input type="checkbox"/> Out-of-Area Equity Plus (OOAPPO) |

Specific Plan Benefit: \_\_\_\_\_

**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.

**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)**

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> New Applicant | <input type="checkbox"/> ADD Dependent/Spouse    | <input type="checkbox"/> Address Change          | <input type="checkbox"/> Name Change |
| <input type="checkbox"/> CANCEL ALL    | <input type="checkbox"/> Cancel Dependent/Spouse | <input type="checkbox"/> COBRA (effective date): | <input type="checkbox"/> PCP Change  |

Group Name:	Group Number:	Sub Group Number:	Subscriber Number:
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Benefit Administrator Signature- Required	Status: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary
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Date Hired: (mm/dd/yyyy)	Effective Date of Coverage: (mm/dd/yyyy) <i>(new hire waiting period must be satisfied)</i>	Coverage Cancellation Date: (mm/dd/yyyy)
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**B. EMPLOYEE INFORMATION (PLEASE PRINT LEGAL NAME)** Use Alternate Mailing Address for this member?  Yes  No

Last Name:	First Name:	Middle Initial:
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Home Address: (no P.O. Box)	City:	State:	Zip Code:
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Social Security Number:	Date of Birth: (mm/dd/yyyy)
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Primary Phone:	Secondary Phone:	Gender:	Disabled:
<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Subscriber Name:
Employer Name:

**B. EMPLOYEE INFORMATION** *(continued)*

**Go Paperless!** Please check the boxes below for your preference in receiving communications from Optima Health.  
 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 1-800-275-3755. To opt out of text messages, text STOP to short code 59270 or call 1-800-275-3755. 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.

**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*

- |  |  |
|--|--|
| <input type="checkbox"/> I decline coverage for myself (and my dependents, if any) | <input type="checkbox"/> I decline coverage for my children only.          |
| <input type="checkbox"/> I decline coverage for my spouse only.                    | <input type="checkbox"/> 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: <i>(mm/dd/yyyy)</i>
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Subscriber Name:
Employer Name:

**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 Optima Health'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.

**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.

<i>Alternate Mailing Address:</i>		<i>City:</i>
<i>State:</i>	<i>Zip Code:</i>	

**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)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Phone:	Secondary Phone:		
PCP Last Name:	PCP First Name:	Provider Number: (If Known)	Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Subscriber Name:
Employer Name:

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

<b>CHILD 1</b>	<input type="checkbox"/> Add	<input type="checkbox"/> Cancel	<b>Use Alternate Mailing Address for this member?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Last Name:		First Name:			Middle Initial:	
Social Security Number:		Date of Birth: <i>(mm/dd/yyyy)</i>		Gender:		Disabled:
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No
PCP Last Name:		PCP First Name:		Provider Number:		Current Patient?
				<i>(If Known)</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>CHILD 2</b>	<input type="checkbox"/> Add	<input type="checkbox"/> Cancel	<b>Use Alternate Mailing Address for this member?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Last Name:		First Name:			Middle Initial:	
Social Security Number:		Date of Birth: <i>(mm/dd/yyyy)</i>		Gender:		Disabled:
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No
PCP Last Name:		PCP First Name:		Provider Number:		Current Patient?
				<i>(If Known)</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>CHILD 3</b>	<input type="checkbox"/> Add	<input type="checkbox"/> Cancel	<b>Use Alternate Mailing Address for this member?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Last Name:		First Name:			Middle Initial:	
Social Security Number:		Date of Birth: <i>(mm/dd/yyyy)</i>		Gender:		Disabled:
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No
PCP Last Name:		PCP First Name:		Provider Number:		Current Patient?
				<i>(If Known)</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>CHILD 4</b>	<input type="checkbox"/> Add	<input type="checkbox"/> Cancel	<b>Use Alternate Mailing Address for this member?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Last Name:		First Name:			Middle Initial:	
Social Security Number:		Date of Birth: <i>(mm/dd/yyyy)</i>		Gender:		Disabled:
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No
PCP Last Name:		PCP First Name:		Provider Number:		Current Patient?
				<i>(If Known)</i>		<input type="checkbox"/> Yes <input type="checkbox"/> 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.*

Subscriber Name:
Employer Name:

**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)
<b>Eligible due to:</b> <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> 65 or over <input type="checkbox"/> Retired	<input type="checkbox"/> End Stage Renal Disease (ESRD) Month/Year:
	<input type="checkbox"/> Disability & Current ESRD Month Year:

**H. CERTIFICATION AND 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 1-800-275-3755. To opt out of text messages, text STOP to short code 59270 or call 1-800-275-3755. 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 \_\_\_\_\_

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

I understand that no coverage will be in force until Optima Health 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 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 Optima Health any change in eligibility of myself and my dependents. I agree to provide supporting documentation that is acceptable to Optima Health if requested.

Subscriber Name:

Employer Name:

**H. CERTIFICATION AND AUTHORIZATION** *(continued)*

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 and that I will receive upon request Optima Health'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 Optima Health 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 Optima Health 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.

I understand any personal medical 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 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 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 Optima Health at 4417 Corporation Lane, Virginia Beach, VA 23462. 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 Optima Health 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 *or print, sign name, and specify title of*  
Legal Representative:

Date: (mm/dd/yyyy)