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

Enrollment Application

IMPORTANT: Incomplete information will delay enrollment. Please use a ball point pen, press firmly and print clearly.

SECTION A To be completed by employer Group No. _____ (For Optima Office Use Only) Subscriber Membership ID No. _____ (For Optima Office use only)

☐ **New** ☐ **Open Enrollment** ☐ **Request for Individual Conversion** ☐ **C.O.B.R.A.** ☐ **PCP or Address Change**

☐ **Cancel All** ☐ **Add Dependent/Spouse** ☐ **Cancel Dependent/Spouse** ☐ **Reinstatement**

Employer Name _____ Effective/Expiration Date of Coverage _____ Employees Social Security No. _____-_____-_____ Hire Date _____

SECTION B To be completed by employee - **(Please Print)**

Last Name _____ First Name _____ Middle Init. _____

Address _____

Zip Code _____ City _____ State _____

Home Phone (_____) _____ Work Phone (_____) _____

SECTION C **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 F, G, and H on the attached Coordination of Benefits form.

SECTION D Please list below all persons to be covered by the enrollment application. Choose a primary care physician by consulting your provider directory. You may choose a different primary care physician for each member of your family. We will need your choice of both a primary care physician and location in order to process this application.

SOCIAL SECURITY NO.		LAST NAME	FIRST NAME, M.I.	DATE OF BIRTH MO./DAY/YR.	M or F	PRIMARY CARE PHYSICIANS AND LOCATION	CURRENT PATIENT?
	SELF			/ /		DR.	YES / NO
	SPOUSE			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO
	CHILD			/ /		DR.	YES / NO

IF YOU ARE BEING OFFERED DENTAL COVERAGE, PLEASE LIST YOUR PLAN DENTAL PROVIDER _____

IF ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE) _____

SECTION E

I apply for Optima Health Plan membership for the persons listed, and agree that I and my family members shall abide by the provisions of coverage in the Evidence of Coverage under which we will be enrolled.

1. I understand that misrepresentation in answering the questions on this application or non-payment of premium or copayment may result in cancellation of membership. All benefits and exclusions are set forth in the Evidence of Coverage. I understand that this application serves as a contract between myself and Optima Health Plan, and that all the provisions outlined herein apply. All monies will be returned if the application is not accepted.
2. I authorize any physician or hospital to disclose to Optima Health Plan any information relating to the individuals specified on this application. I further understand and agree that no benefits shall take effect until this application is approved by Optima Health Plan. An Evidence of Coverage and Face Sheet will be issued. This application shall become a part of the Group Agreement. I understand that I or my authorized representative may receive a copy of this enrollment application upon request. I agree that a photographic copy of this authorization shall be valid as the original. I understand that for the purpose of collecting information in connection with 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.
3. I understand that it is my responsibility to report to Optima Health Plan any change in the eligibility of my dependents. That all dependents listed are legally my responsibility and claimed with the I.R.S.. If requested, documentation will be supplied.
4. I understand I am obligated to select a Sentara primary care physician for myself and my covered dependents. I further understand that all services, except emergency services, must be authorized or provided by the primary care physician. I also understand that I am obligated to pay applicable copayments at the time services are rendered.

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____

*Incomplete or incorrect information may cause a delay in your enrollment and the processing of claims.