❑ Optima Health Plan (HMO, POS)
❑ Optima Health Insurance Company (PPO, OOA PPO)
❑ CommunityHealth by Optima Health Insurance Company

Enrollment Application & Waiver
Coordination of Benefits

IMPORTANT: Incomplete information will delay enrollment. ***Please complete all sections in blue or black ink.***

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 Number	Group Name	Benefit Administrator Signature – Required	Subscriber Membership Number

Date Hired	Status	Effective Date of Coverage (new hire waiting period must be satisfied)	Coverage Cancellation Date
_____/_____/_____	❑ Hourly ❑ Salaried	_____/_____/_____	_____/_____/_____

B. EMPLOYEE INFORMATION *(PLEASE PRINT LEGAL NAME)*

Last Name	First Name	Middle Initial	Date of Birth Mo. / Day / Year	Social Security No.
				_ _

Home Address	City	State	Zip Code

Home Phone	Work Phone	Sex	Marital Status
		❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

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. If electing coverage for self and all dependents, I may disregard section C.

C. WAIVER OF EMPLOYEE AND/OR DEPENDENT HEALTH COVERAGE

(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 children 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:** _____

D. ENROLLMENT INFORMATION

- If applying for Optima Health Plan Health Maintenance Organization or the Optima Health Plan Point of Service Plan, please select a primary care physician from the Plan's Provider Directory for each family member listed, the PPO and OOA Plans do not require primary care selection.
- Documentation such as a birth certificate or marriage license is required if enrolling spouses or dependents with different last names.
- If requesting coverage for a full-time student between the ages of 19 and 24, please provide proof of full-time status.

Last Name	First Name, Middle Initial	Social Security	Date of Birth Mo/Day/Year	Male/ Female	Primary Care Physician & Address	Current Patient
Employee: *Employee information will be taken from Section B above. If this is an HMO or POS plan, please indicate PCP in the box to the right.* ⇒						❑ Yes ❑ No
Spouse ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No
Child ❑ Add ❑ Cancel		- -	/ /	❑ M ❑ F		❑ Yes ❑ No

E. PROOF OF PRIOR COVERAGE

- Newly enrolled members will be subject to a pre-existing condition exclusion for the first twelve (12) months following their date of enrollment unless they have twelve (12) months of creditable coverage before enrollment. **To receive credit for your prior coverage, please try to obtain a Certificate of Creditable Coverage** from your previous insurance carrier or your current/previous employer and submit it to Optima with this application.** If you have had a 63-day or greater break in coverage within the last twelve months, you will not receive credit for any coverage which was in effect before that break in coverage.

****Please attach the Certificate of Creditable Coverage to the application at time of submission.**

F. OTHER COVERAGE INFORMATION (Required before enrollment can be completed.)

- Will anyone to be covered by this plan carry coverage in addition to this Plan?
  ❑ No If NO, skip to Section G ❑ Yes If YES, then please provide the following information about that coverage.

Insured Person (Name)	Identification (Policy) No.	Effective Date
Name of Insurance Company	If "Group" Coverage, Name of Employer or Organization Providing Coverage	

List Anyone Applying for Coverage Who Will Also Be Covered by This Insurance.

If Medicare Coverage:

Covered Person (Name)	HIC Number	Effective Date of Part A	Effective Date of Part B

Eligible Due to: ❑ Age ____ ❑ Disability _____ ❑ End Stage Renal Disease (ESRD) Mo ____ Year ____ ❑ Disability & Current ESRD Mo ____ Year ____ — 65 or Over ❑ Working ❑ Retired

Eligible Due to: ❑ Age ____ ❑ Disability _____ ❑ End Stage Renal Disease (ESRD) Mo ____ Year ____ ❑ Disability & Current ESRD Mo ____ Year ____ — 65 or Over ❑ Working ❑ Retired

G. APPLICATION DECLARATION AND AUTHORIZATION

Please read and provide signature and date. Signature is REQUIRED for processing enrollment.

The undersigned applicant certifies that he/she has read, or has had read to him/her, the completed application and realizes that any false statement or misrepresentation in the application may result in loss of coverage under this policy.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my health or my dependents or their health, to give Sentara Health Plan as agent for the insurer, Optima Health Plan, Optima Health Insurance Company to the company checked on page 1 of this application, any such information for the purposes of compiling an accurate evaluation of this application and for the payment of claims. Authorization to disclose information for the payment of claims is valid for the term of coverage. I do understand that I or my authorized representative may receive a copy of this application upon request. I agree that a photographic copy of this Authorization shall be as valid as the original and that for the purpose of collecting information in connection with application for coverage, policy reinstatement, or a request for change in policy benefits, this Authorization shall be valid for thirty (30) months from the date shown below.

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 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 not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on each Member ID card issued to me. I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for the coverage has not been made by my employer.

I am applying for health coverage for the persons listed, and agree that we shall abide by the provisions of coverage in the coverage document under which we will be enrolled. I understand that it is my responsibility to report to the plan indicated on page one (1) any change in the eligibility of my dependents and that all dependents listed are legally my responsibility. If requested, documentation will be supplied. I understand that I am obligated to select a Plan-participating primary care physician for myself and for my covered dependents if choosing Optima Health Plan Health Maintenance Organization or Optima Health Plan Point of Service. I further understand that all services, except emergency services, must be authorized or provided by the primary care physician if choosing Optima Health Plan or Optima Health Plan Point of Service. I also understand that I am obligated to pay applicable copayments at the time services are rendered.

X

Employee Signature In Ink **Date**

Group Number	Group Name	*Employee Health Questionnaire*
Effective Date	Subscriber Membership Number	Subscriber Name

H. HEALTH QUESTIONS *(TO BE COMPLETED BY EMPLOYEE FOR EMPLOYEE AND ALL DEPENDENTS LISTED IN SECTIONS B & C)*

Within the past 5 years, have you, or any person on this application, had or been treated for the following diseases or impairments? Please check the appropriate box beside the condition and **provide details in SECTION I for any condition checked "yes":**

Yes	No		Yes	No		Yes	No	
❑	❑	Liver Disorder (Hepatitis/Cirrhosis)	❑	❑	High Blood Pressure	❑	❑	Heart Problems
❑	❑	Kidney/Bladder Problems	❑	❑	Diabetes	❑	❑	Thyroid Trouble
❑	❑	Stomach/Intestinal Disorder	❑	❑	Stomach Ulcers	❑	❑	Gall Bladder Trouble
❑	❑	Disease/Disorder of Spine or Back	❑	❑	Arthritis	❑	❑	Tumors
❑	❑	Cancer	❑	❑	Alcohol or Drug Abuse	❑	❑	HIV
❑	❑	Sexually Transmitted Disease	❑	❑	Epilepsy	❑	❑	Tuberculosis
❑	❑	Asthma (Date of last attack _____/_____/_____)	❑	❑	Current Pregnancy (Due Date _____/_____/_____)	❑	❑	Brain Disorder
❑	❑	Nervous/Mental or Psychological Disorder	❑	❑	Acquired Immune Deficiency Syndrome (AIDS)	❑	❑	Connective Tissue Disease (Lupus)
❑	❑	Multiple Sclerosis	❑	❑	Hemophilia	❑	❑	Allergies
❑	❑	High Cholesterol	❑	❑	Gout	❑	❑	Sleep Apnea

Additional Information About You and Your Dependents:

1. Employee: Height _____ ft. _____ in. Spouse: Height _____ ft. _____ in.
   Weight _____ lbs. Weight _____ lbs.

2. Within the past five (5) years, have you, or any person named on this application, consulted a physician or other provider for medical or surgical treatment or advice for any condition NOT listed in SECTION H?
   ❑ No ❑ Yes ***(If Yes, please provide details in SECTIONS I (a) and I (b).)***

3. Within the past five (5) years, have you, or any person named on this application, been advised to have an operation which has not been performed or to enter a treatment program not currently being received?
   ❑ No ❑ Yes ***(If Yes, please provide details in SECTIONS I (a) and I (b).)***

4. Within the past five (5) years, have you, or any person named on this application, been declined on a previous health insurance application?
   ❑ No ❑ Yes ***(If Yes, please provide details in SECTIONS I (a) and I (b).)***

I. (a) PRESCRIPTION MEDICATION HISTORY

Please provide information on any prescribed medication (including injections) that you or any of your listed dependents have used within the past 5 years. Please provide information on past and current prescription drug usage. If you need more space, please attach additional documentation to this application.

Individual's First Name	Medication	Dosage (amount and frequency)	Beginning date of use	Ending date of use

I. (b) MEDICAL TREATMENT HISTORY

If you checked "Yes" to any part of SECTION H, please provide complete information regarding diagnosis, conditions, or treatments – include all hospitalizations, surgery, and diagnostic testing. If you need more space, continue on reverse.

Individual's First Name	Diagnosis	Date Diagnosed	Attending Physician's Name and Address	Complete Recovery?

I. (b) MEDICAL TREATMENT HISTORY *CONTINUED*

If you checked "Yes" to any part of SECTION H, please provide complete information regarding diagnosis or condition; treatments – include all hospitalizations, surgery, and diagnostic testing. If you need more space, please attach additional documentation to this application.

Individual's First Name	Diagnosis	Date Diagnosed	Attending Physician's Name and Address	Complete Recovery?

J. MEDICAL PROFILE SUPPLEMENT CERTIFICATION

Please read and provide signature and date. Signature is REQUIRED for underwriting review.

The undersigned applicant certifies that he/she has read, or has had read to him/her, the completed application and realizes that any false statement or misrepresentation in the application may result in loss of coverage under this policy.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my health or my dependents or their health, to give Sentara Health Plan as agent for the insurer, Optima Health Plan, Optima Health Insurance Company to the company checked on page 1 of this application, any such information for the purposes of compiling an accurate evaluation of this application and for the payment of claims. Authorization to disclose information for the payment of claims is valid for the term of coverage. I do understand that I or my authorized representative may receive a copy of this application upon request. I agree that a photographic copy of this Authorization shall be as valid as the original and that for the purpose of collecting information in connection with application for coverage, policy reinstatement, or a request for change in policy benefits, this Authorization shall be valid for thirty (30) months from the date shown below.

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 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 not as an agent of the insurer. I understand that coverage is not in force until the effective date shown on each Member ID card issued to me. I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for the coverage has not been made by my employer.

I am applying for health coverage for the persons listed, and agree that we shall abide by the provisions of coverage in the coverage document under which we will be enrolled. I understand that it is my responsibility to report to the plan indicated on page one (1) any change in the eligibility of my dependents and that all dependents listed are legally my responsibility. If requested, documentation will be supplied. I understand that I am obligated to select a Plan-participating primary care physician for myself and for my covered dependents if choosing Optima Health Plan Health Maintenance Organization or Optima Health Plan Point of Service. I further understand that all services, except emergency services, must be authorized or provided by the primary care physician if choosing Optima Health Plan or Optima Health Plan Point of Service. I also understand that I am obligated to pay applicable copayments at the time services are rendered.

Employee Name *(Please Print)*

Company Name

X

Employee Signature In Ink

Date

Daytime Phone