

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

If you are enrolling your spouse or your dependents, read this first!

The following situations require that you provide additional information or documentation so that your spouse or your dependents can be enrolled in your health plan. Without these documents your I.D. cards will not be issued.

Spouses or children with last names different from yours:

Be sure to include a copy (do not send the original) of *one* of these:

- Marriage License (spouse)
- Birth Registration Certificate that establishes parentage (dependents)
- Adoption Decree (dependents)
- Legal Guardianship Court Decree (dependents)
- Qualified Medical Child Support Order (dependents)

Dependents age 19 and over attending school on a full-time basis:

Be sure to include a copy (do not send the original) of *one* of these:

- Current Registration (showing total credit hours)
- Formal letter from school (indicating full-time status)

Handicapped dependents age 19 and over:

Handicapped dependents age 19 and over are eligible for continued coverage under other limited circumstances. Include a written verification of the handicap from a licensed physician. Call member services for additional information.

Check your application carefully to be sure all birthdays, Social Security numbers and phone numbers are correct. Please include any certificate of creditable coverage as described on the back of this application.



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**Optima Health Insurance Company
Premier PPO
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. _____ Subscriber Membership ID No. _____
(For Office Use Only) (For 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 _____ Employee's Social Security No. _____ Hire Date _____

SECTION B TO BE COMPLETED BY EMPLOYEE - (PLEASE PRINT LEGAL NAME)

Last Name _____ First Name _____ Middle Init. _____

Address _____

City/State/Zip _____ Email _____

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 Insurance Company, when this coverage takes effect? Yes No If YES, please complete Sections F, G, and H on the Coordination of Benefits form.

SECTION D Please list below all persons to be covered by the enrollment application.

SOCIAL SECURITY NO.		LAST NAME	FIRST NAME, M.I.	DATE OF BIRTH MO/DAY/YR	M O F
	SELF			/ /	
	SPOUSE			/ /	
	CHILD			/ /	
	CHILD			/ /	
	CHILD			/ /	
	CHILD			/ /	

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

SECTION E

I apply for Optima Health Insurance Company coverage for myself and the family members listed, and agree that I and my family members shall abide by the provisions of coverage in the Group Policy and Certificate of Insurance under which we will be enrolled.

I understand that misrepresentation in answering the questions on this application or non-payment of premiums, copayment or coinsurance may result in cancellation of coverage. All benefits and exclusions are set forth in the Certificate of Insurance. I understand that this application serves as a contract between myself and Optima Health Insurance Company, and that all the provisions outlined herein apply. All monies will be returned if the application is not accepted.

I authorize any physician or hospital to disclose to Optima Health Insurance Company medical and other information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. I understand by signing this form I give Optima Health Insurance Company the right to receive and release information needed to administer the coordination of benefits (COB) provisions. I further understand and agree that no benefits shall take effect until this application is approved by Optima Health Insurance Company. A Certificate of Insurance and Schedule of Benefits will be issued. This application shall become a part of the Group Policy. 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 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; 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.

I understand that it is my responsibility to report to Optima Health Insurance Company any change in the eligibility of my dependents. I understand that all dependents listed are legally my responsibility as claimed with the I.R.S. If requested, documentation will be supplied. I also understand that I am obligated to pay applicable copayments or coinsurance at the time services are rendered.

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____

IMPORTANT INFORMATION

If you have questions concerning your benefits or how to receive care call member services at the number on your ID card. Member services are available to help you Monday - Friday 8 - 5.

If services are obtained before your ID card is issued and you are deemed ineligible, you will be responsible for payment of services rendered.

When Can I See My Physician?

When your coverage becomes effective, you may call at any time to make an appointment to see a physician.

What If I Have An Emergency?

If you have a medical emergency that requires immediate attention at any time of the day or night, call your physician or the After Hours number on your ID card. Your physician, or the After Hours nurse will give you instructions on how best to handle the emergency. Unauthorized emergency care is retrospectively reviewed to determine medical necessity. You may be responsible for charges related to an emergency visit if it is later determined that a medical emergency did not exist.

In extreme circumstances, when the emergency is such that your life or health would be threatened by a delay in seeking care you should go directly to the nearest participating emergency or urgent care provider for treatment. If not, proceed to the nearest emergency facility. The Plan should be notified within 48 hours that you have received emergency care.

What If I Have Another Insurance Carrier?

Coordination of Benefits applies when an individual is insured under two or more insurance carriers and is permitted to recover charges for medical expenses incurred. Any duplication of insurance benefits needs to be noted in Section C.

Under the Health Insurance Portability and Accountability Act of 1996, you may be eligible for credit toward the application of a pre-existing condition exclusion period for coverage under a prior health plan. You should try to obtain an Certificate of Insurance from your previous insurance carrier and submit it to the plan with the application in order to receive credit. 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. See your Certificate of Insurance for further details.