OptimaHealth
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401

FOR PLAN USE ONLY
Subscriber #: _____
Date: _____

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._____ (For Office Use Only) Subscriber Membership ID No. _____ (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 or 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 _____

READ THE BACK OF THE FORM TO SEE HOW THE PLAN WORKS FOR YOU.