



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

# Optima Health Plan 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 Plan, 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. 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 O R 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 ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE) \_\_\_\_\_**

**SECTION E**

I apply for OPTIMA HEALTH PLAN 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 Evidence of Coverage under which we will be enrolled.

I understand that misrepresentation in answering the questions on this application or non-payment of premiums or copayment may result in cancellation of coverage. 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.

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 as valid as the original. I understand that, for the purpose of collecting information in connection with this authorization, 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 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. I understand I am obligated to select a participating primary care physician for myself and my covered dependents and if I did not one will be assigned. 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.