Print Form | Save Form

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FOR PLAN USE ONLY
Subscriber #:
Date:

OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

Optima Health Plan | *OptimaFit® OptimaFit Direct OptimaFit Standard*
Application for Individual Health Coverage

☐ New Applicant ☐ Change/modification of existing policy

Effective Date: Member Name: _____

_____ Member Number: _____

IMPORTANT:

- This health plan is offered and underwritten by Optima Health Plan. In this document we may use the term Optima Health to refer to this plan.
- Incomplete information will **delay enrollment.** Please complete all sections in blue or black ink.
- Social Security numbers are to be provided for the primary subscriber, spouse and dependent child(ren) covered by this plan.
- If you are adding or removing a spouse or dependent, **please attach supporting documentation within 60 days from the triggering event**. Examples include a marriage or birth certificate, adoption papers, etc.
- Please note that this application is **not valid** if your intent is to enroll on a plan that is offered on the Health Insurance Marketplace. For those plans, please visit *www.healthcare.gov/marketplace/individual*.

Pediatric Oral Health Benefits:
This policy does not provide the ACA-required minimum essential pediatric oral health benefits. Stand-alone dental coverage that includes such benefits must be available to you for purchase separately from a qualified stand-alone dental plan.

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT (Check all that apply)

Change/Correction: ☐ Name Change ☐ Plan Reinstatement ☐ Address Change ☐ Plan Change ☐ Telephone Change ☐ Date of Birth Correction ☐ Email Address

Date of Qualifying Event: *(mm/dd/yyyy)*

Add Dependent(s) ☐ Marriage ☐ Newborn ☐ Adoption ☐ Loss of Coverage ☐ Other: Please note:

Remove Dependent(s) ☐ Marriage ☐ Divorce ☐ Medicare ☐ Death ☐ Age Out (26 and 65) ☐ Other: Please note:

B. PLAN SELECTION- POLICY DEDUCTIBLE and/or COINSURANCE

OptimaFit Direct Plan Options

☐ OptimaFit Gold 1300 20% Direct ☐ OptimaFit Gold 2200 20% Direct ☐ OptimaFit Silver 3800 25% Direct ☐ OptimaFit Silver 6600 30% Direct

☐ OptimaFit Bronze 6250 20% HSA Direct ☐ OptimaFit Bronze 7200 40% Direct ☐ OptimaFit Silver 3500 30% Direct ☐ OptimaFit Silver 3000 30% HSA Direct

OptimaFit Standard Plan Options

☐ OptimaFit Gold 2000 25% Standard ☐ OptimaFit Silver 5800 40% Standard ☐ OptimaFit Bronze 9100 0% Standard

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C. PRIMARY APPLICANT INFORMATION *(PLEASE PRINT LEGAL NAME)*

- ***If this is a child only application, please include the Parent/Guardian name, address, date of birth, relationship to child and primary phone number in this section. The child only applicant information should be included under the Child 1 section on page 3.***

Last Name:	First Name:	Middle Initial:

Home Address: *(no P.O. Box)*

City:	State:	Zip Code:

Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female	Primary Phone: ☐ Mobile ☐ Home ☐ Work	Secondary Phone: ☐ Mobile ☐ Home ☐ Work

Mailing Address: *(If different from home address above)*	City:	State:	Zip Code:

Go Paperless!

Please check the box below to enroll in our Paperless Program and consent to receive electronic communications from Optima Health. By enrolling in our Paperless Program, you are consenting to receive email communication and, upon enrollment, electronically receiving policy documents through your secure Optima online portal account or app, rather than in paper form through personal delivery or the U.S. Mail.

Email Address: _____

☐ I agree to accept electronic communications notifying me of important health plan information, including but not limited to, the Certificate of Insurance, Evidence of Coverage, plan updates and Uniform Summary of Benefits documents.

Receive wellness reminders and other important information

By providing your phone number, you are consenting to Optima Health and its representatives contacting you at any phone number you have provided to us, which may include mobile phone numbers. You understand that you are not required to agree, and agreeing is not a condition of being an Optima Health member or receiving health care. Communications directed to these phone numbers may be carried out using automated dialing/delivery devices, direct dial, text message, SMS or RCS messages, ringless voicemail, push notifications, and prerecorded or artificial voices. Communications may include, but may not be limited to, information regarding medication, wellness, preventive care, health plan enrollment, communication preferences, payment, and other information Optima Health or its representatives believe may interest or be relevant to you. Communications and their content, which may include health information, will not be encrypted. You may revoke this consent at any time. To opt out of phone calls, call 1-866-514-5916. To opt out of text messages, text STOP to short code 59270 or call 1-866-514-5916. If you are not the subscriber to the phone number you provided, then you agree that you have obtained the subscriber's consent to receive these communications. Optima Health will not charge you for these communications. Carrier message and data rates may apply.

Primary Care Physician: (PCP)

If applying for Optima Health Plan Health Maintenance Organization (HMO) please select a primary care physician from the Plan's Provider Directory for each family member listed.

PCP Last Name:	PCP First Name:

Provider Number: *(If known)*

Current Patient? ☐ Yes ☐ No

If you are 21 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

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Parent/Guardian Information *(if child only application)*	***Relationship to Child:***	☐ Parent	☐ Guardian

Parent/Guardian Last Name:	Parent/Guardian First Name:	Date of Birth: *(mm/dd/yyyy)*

Home Address: (no P.O. Box)	*City:*	*State:*	*Zip Code:*

D. HEALTH SAVINGS ACCOUNT *(if applicable)*

Health Savings Account (HSA) Administration - If you have chosen the **Equity/HSA** eligible high deductible plan, you are eligible to establish a Health Savings Account (HSA). HealthEquity is Optima Health's preferred vendor for HSA administration.

Do you want to establish a HSA?

Effective date:
(mm/dd/yyyy) _____

☐ **Yes**, please DO establish or continue my existing health savings account for me with HealthEquity.

☐ No, please DO NOT establish a health savings account for me with HealthEquity.

E. ALTERNATE MAILING ADDRESS

If your spouse or any dependent should receive plan information to an address other than that listed under Section C Primary Applicant Information, please provide that address and the plan member's name.

Applicable Member:	Alternate Mailing Address:	City:	State:	Zip Code:

- *For additional addresses, please reprint this page and continue to fill out for additional policy members.*

F. FAMILY INFORMATION

Please complete only if your spouse and/or dependent children are applying for coverage.

- If enrolling dependents, how many? _____

SPOUSE ☐ Add ☐ Cancel **Use Alternate Mailing Address for this member?** ☐ Yes ☐ No

Last Name:	First Name:	Middle Initial:

Social Security Number:	Date of Birth: *(mm/dd/yyyy)*	U.S. Citizen: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female	Primary Phone:	Secondary Phone:
	Email Address:	

NOTE: Primary Care Physician: (PCP) If applying for Optima Health Plan Health Maintenance Organization (HMO) please select a primary care physician from the Plan's Provider Directory for each family member listed.

PCP Last Name:	PCP First Name:

Provider Number: *(If known)*

Current Patient? ☐ Yes ☐ No

If you are 21 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

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F. FAMILY INFORMATION *(continued)*

CHILD 1 ☐ Add ☐ Cancel **Use Alternate Mailing Address for this member?** ☐ Yes ☐ No

Last Name: | First Name: | Middle Initial:

Social Security Number: | Date of Birth: *(mm/dd/yyyy)* | U.S. Citizen: ☐ Yes ☐ No | Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female | Primary Phone: | Secondary Phone:

Email Address:

Primary Care Physician (PCP): *(If needed)*

PCP Last Name: | PCP First Name:

Provider Number: *(If known)* | Current Patient? ☐ Yes ☐ No

If you are 21 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

CHILD 2 ☐ Add ☐ Cancel **Use Alternate Mailing Address for this member?** ☐ Yes ☐ No

Last Name: | First Name: | Middle Initial:

Social Security Number: | Date of Birth: *(mm/dd/yyyy)* | U.S. Citizen: ☐ Yes ☐ No | Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female | Primary Phone: | Secondary Phone:

Email Address:

Primary Care Physician (PCP): *(If needed)*

PCP Last Name: | PCP First Name:

Provider Number: *(If known)* | Current Patient? ☐ Yes ☐ No

If you are 21 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

CHILD 3 ☐ Add ☐ Cancel **Use Alternate Mailing Address for this member?** ☐ Yes ☐ No

Last Name: | First Name: | Middle Initial:

Social Security Number: | Date of Birth: *(mm/dd/yyyy)* | U.S. Citizen: ☐ Yes ☐ No | Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female | Primary Phone: | Secondary Phone:

Email Address:

Primary Care Physician (PCP): *(If needed)*

PCP Last Name: | PCP First Name:

Provider Number: *(If known)* | Current Patient? ☐ Yes ☐ No

If you are 21 years of age or older, have you used tobacco regularly within the past 6 months (4 or more times per week on average excluding religious or ceremonial uses)? ☐ Yes ☐ No

- *If you have more than three (3) dependents please reprint this page and continue to fill out the information requested for all eligible dependents.*

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

Will anyone who is to be covered by this plan carry coverage in addition to this Plan?

☐ No If NO, skip to section H.

☐ Yes If YES, then please provide the following information about that coverage.

Insured Person (Name):	Identification (Policy) No.
Effective Date: (mm/dd/yyyy)	Name of employer or organization providing coverage:
Name of Insurance Company:	List anyone applying for coverage who will also be covered by this Insurance.

If Medicare Coverage:

If more than one person has Medicare Coverage, please reprint this page and complete the information requested.

Covered Person: (Name)	HIC Number:
Effective Date: Part A (mm/dd/yyyy)	Effective Date: Part B (mm/dd/yyyy)

Eligible due to: ☐ Age ☐ Disability ☐ 65 or over ☐ Retired

☐ End Stage Renal Disease (ESRD) ☐ Disability & Current ESRD

Month/Year: Month/Year:

- *If you have a family member who is enrolled on more than one additional health plan, please reprint this page and continue to fill out the additional coverage information for any coverage that will be active in addition to the plan you are applying for.*

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

I confirm that I have read this replacement notice and have checked and/or initialed one of the following regarding my application:

☐ This application is for coverage under an Optima Health Individual policy which if issued **will not replace other coverage presently in force**.

☐ This application is for coverage under an Optima Health Individual policy which if issued **will replace other coverage presently in force.** Please read the following additional information regarding replacement coverage:

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Optima Health. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

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H. INITIAL PAYMENT INFORMATION- Please select one payment type

CREDIT CARD / DEBIT CARD

If paying by credit card or debit card, please wait to receive either your welcome letter or initial invoice from Optima Health with instructions on how to make payment.

AUTOMATIC BANK DEDUCTION

Banking Information

If your banking information is different for your initial payment and your ongoing electronic payments, please fill out the next page and provide the information for ongoing payment transactions.

Bank Routing Number:	Bank Account Number:		
Primary Name on Bank Account:			
Name of Financial Institution:	Branch Phone Number:		
Branch Address:	City:	State:	Zip:

CHECK, MONEY ORDER, OR CASHIERS CHECK

To ensure proper posting, please include member name, member number, and invoice number (if applicable) on Check, Money Orders, or Cashiers Check.

Mail Payment to:
Optima Health
4456 Corporation Lane
Suite 336
Virginia Beach, VA 23462

MONEYGRAM

Make convenient premium payments at MoneyGram Locations across Virginia,
including most 7-Eleven, CVS and Walmart locations.
(No service fees apply)

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I. ON-GOING MONTHLY PAYMENT INFORMATION- Payments Must Be Made Monthly

AUTOMATIC CREDIT CARD / DEBIT CARD

Instructions for automatic credit or debit card payments are available on our website, during or after initial payment is made.

AUTOMATIC BANK DEDUCTION

Banking Information

If your banking information is different for your initial payment and your ongoing electronic payments, please fill out the previous page and provide the information for the initial payment transaction.

Bank Routing Number:	Bank Account Number:		
Primary Name on Bank Account:			
Name of Financial Institution:	Branch Phone Number:		
Branch Address:	City:	State:	Zip:

CHECK, MONEY ORDER, OR CASHIERS CHECK

To ensure proper posting, please include member name, member number, and invoice number (if applicable) on Check, Money Orders, or Cashiers Check.

Mail Payment to:
Individual Product OHP
PO Box 75892
Baltimore, MD 21275-5892

PRE-PAID DEBIT

Payments with Pre-Paid Debit Cards: Calls must be made monthly to (757)687-6434 or (888)737-5479

MONEYGRAM

Make convenient premium payments at MoneyGram Locations across Virginia,
including most 7-Eleven, CVS and Walmart locations.
(No service fees apply)

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J. CERTIFICATION AND AUTHORIZATION

Receive reminders to renew before your plan expires next year

By providing your phone number, you are consenting to Optima Health and its representatives contacting you at any phone number you have provided to us, which may include mobile phone numbers. You understand that you are not required to agree, and agreeing is not a condition of being an Optima Health member or receiving health care. Communications directed to these phone numbers may be carried out using automated dialing/delivery devices, direct dial, text message, SMS or RCS messages, ringless voicemail, push notifications and prerecorded or artificial voices. Communications may include, but may not be limited to marketing messages to promote Optima Health's products and services and renewal reminders. You may revoke this consent at any time. To opt out of phone calls, call 1-866-514-5916. To opt out of text messages, text STOP to short code 59270 or call 1-866-514-5916. If you are not the subscriber to the phone number you provided, then you agree that you have obtained the subscriber's consent to receive these communications. Optima Health will not charge you for these communications. Carrier message and data rates may apply.

Signature of Applicant _____ Date _____

The following section must be signed and dated by the primary applicant.

I understand that no coverage will be in force until Optima Health determines eligibility for coverage, and notifies me of the first effective date of coverage. I understand that my enclosed premium will be applied to coverage for eligible person(s); and I understand that the premium will be refunded if no persons are eligible for coverage selected and no other coverage is accepted. I also understand that premiums not paid in accordance with this provision, and the terms of the policy, will result in the non-renewal or discontinuance of the policy issued from this application.

I understand that the policy that I am applying for is an individual health insurance policy, and I understand that the policy, if issued, shall not be used as an employer provided healthcare benefit plan. I certify that no employer of any person covered under this policy may pay any premium for this coverage, directly or indirectly, including through wage adjustment. I understand that "employer" does not include a trade of business wholly owned by an individual or individual and spouse that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

I understand that coverage is not in force until the effective date shown on the Schedule of Benefits issued to me or my dependents. I am applying for health coverage for the persons listed on the application, and I agree that we shall abide by the provisions of coverage in the policy document under which we will be enrolled. I understand that it is my responsibility to report to Optima Health any change in eligibility of myself and my dependents. I agree to provide supporting documentation that is acceptable to Optima Health if requested.

I understand that Optima Health may receive and collect personal information from persons other than me. The collected personal or privileged information may be disclosed to third parties without authorization. I understand that I have a right to access and correct all personal information collected in reference to my policy and that I will receive upon request Optima Health's complete notice of information collection and disclosure practices.

I hereby authorize any provider of health services or any insurance company that has any personal medical records or knowledge of my health or my dependents' health to give to Optima Health any such personal medical information for the purposes of administering coordination of benefits provisions and for the payment of claims once enrolled. This Authorization shall extend to representatives of Optima Health as needed to fulfill the purposes of the disclosure. This Authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record.

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J. CERTIFICATION AND AUTHORIZATION *(continued)*

I understand any personal medical information received by Optima Health pursuant to this application is subject to restrictions on disclosure to others as set forth under state and federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization, and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I, or my authorized representative, are entitled to receive a copy of this Authorization upon request, and I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that for the purposes of processing and payment of claims and for administration of coordination of benefits provisions this Authorization is valid for the term of the policy.

I understand that I can revoke this Authorization at any time by giving written notice to Optima Health at 4417 Corporation Lane, Virginia Beach, VA 23462. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the Authorization prior to receiving notice of my revocation. 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 for the policy.

If a legal representative signs on behalf of the applicant or any other person to be covered, the legal representative's signature constitutes an attestation that the legal representative possesses the authority to sign on behalf of the individual. I further understand that I or my legal representative may receive a copy of this application upon request.

If you or any of your covered dependents are covered by more than one health plan, benefits under your Optima Health plan will be coordinated so that the same health care services don't get paid for twice.

I, and my agent (if applicable), hereby certify that I have read, or have had read to me, the completed application; and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under this policy.

The following section must be signed and dated by the primary applicant.

Signature of Primary Applicant *or print, sign name, and specify title* of Legal Representative:	Date: (mm/dd/yyyy)
Print Agent name if applicable:	Date: (mm/dd/yyyy)
Signature of Agent if applicable:	Date: (mm/dd/yyyy)

Agency Number:	Agent Number:	Receipt Date: (mm/dd/yyyy)
Primary Phone:	Fax Number:	
Email Address:		