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

York County School Division Enrollment Application

IMPORTANT: Incomplete information will delay enrollment. Please use a ball point pen, press firmly and print clearly.

Section 1

☐ **NEW** ☐ **Open Enrollment** ☐ **Continuation of Coverage** ☐ **C.O.B.R.A.**

☐ **Cancel All** ☐ **Add Dependent/Spouse** ☐ **Cancel Dependent/Spouse** ☐ **Reinstatement**

Effective/Termination Date	Employee's Social Security No.	Hire Date

Section 2

Optima Health Plan Selection:
☐ POS 250/20 ☐ Equity POS 3000/0%

Section 3

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

Last Name: ____________ First Name: ____________ Middle Init. ______

Address: ____________ Email: ____________

City/State/Zip: ____________ Date of Birth: ____________ **MO/DAY/YR** Gender: ☐ **Male** ☐ **Female**

Section 4

NOTE: Complete this section only if you have selected the Equity plan in Section 2.

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

Do you want to establish a HSA account? Effective Date: ____________

☐ 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.

Section 5

Please list below all dependents to be covered by the enrollment application.

ADD/ CANCEL	Social Security No.		Last Name	First Name, MI	Date of Birth MO/DAY/YR	M/F
		SPOUSE			/ /	
		CHILD			/ /	
		CHILD			/ /	
		CHILD			/ /	
		CHILD			/ /	

IF ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE, ETC.) ____________

Section 6

AUTHORIZATION

Signature of Applicant ____________ Date ____________

Benefit Administrator ____________ Date ____________

OptimaHealth

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Coordination of Benefits Information Page

* Please retain a copy of this coordination of benefits page for your records.

Applicant's Name: ______________________ Soc. Sec. #: ______________________

Date of Birth: ______________________

NOTE: Complete section 1 and section 3 if you have additional commercial insurance.
Complete section 2 and section 3 if you have Medicare.

SECTION 1 (Commercial Insurance)

Name of other Health Insurance Company: ______________________

Address: ______________________

Phone Number: ______________________

Policy Number: ______________________ Effective Date: ______________________

Employer: ______________________

Group Number: ______________________

Policyholder's Name: ______________________

Birthdate: ______________________

List family members covered by this insurance: ______________________

SECTION 2 (Medicare Information)

Applicant: ______________________ Claim#: ______________________

Hospital Insurance (Part A) Effective Date: ______________________

Hospital Insurance (Part B) Effective Date: ______________________

Are you retired: Yes ☐ No ☐ Retirement date: ______________________

Spouse: ______________________ Claim#: ______________________

Hospital Insurance (Part A) Effective Date: ______________________

Hospital Insurance (Part B) Effective Date: ______________________

Is your spouse retired: Yes ☐ No ☐ Retirement date: ______________________

SECTION 3

I hereby certify that except as reported above, no service or payments are provided or are recoverable through any other group health insurance or group health service plan.

	Date: