VIRGINIA APPLICATION

OPTIMUM CHOICE, INC.™ A UnitedHealthcare® Company

OPTIMUM CHOICE, INC.™ A UnitedHealthcare® Company PREFERRED

MAMSI Life and Health Insurance Company A UnitedHealthcare® Company

P.O. Box 941, Frederick, MD 21705-0941

❑ HMO ❑ Preferred

❑ COBRA - First Date on COBRA _____

- ☐ New Enrollment
- ☐ Dependent Addition
- ☐ Re-enrollment
- ☐ Disenroll
- ☐ Address Change
- ☐ Primary Care Physician Change
- ☐ Conversion
- ☐ Name Change

A. Other Insurance Information

Do you or any OCI family member have other health insurance that will be in effect at the same time as your OCI policy? ☐ Yes ☐ No

Health Insurance Company _____

Phone Number _____ Policy Number _____

In the past seven years, have you or any family member been treated for injuries from an accident? ☐ Yes ☐ No

Are you or any OCI family member covered by Medicare? ☐ Yes ☐ No

If yes, Medicare number: _____

B. Member Information

Social Security Number	Group Policy Number	Effective Date	Member Number
___-___-____			

Name (Last) (First) (MI)	Street Address or P.O. Box Number	
Birth Date / Sex / Previous Membership in OCI? ☐ Yes ☐ No	City	State / ZIP Code
Home Phone ( ) / E-Mail Address	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	If adding a spouse, please give date of marriage:
Name of Employer	Date Employed	Business Phone ( )
Select **Your** Primary Care Physician / Physician Code	Are you currently a patient of this Physician? ☐ Yes ☐ No	

C. Dependent Information

Select a Primary Care Physician from the list provided (a different doctor may be selected for each person). Note: All unmarried children ages 19-23 must be full-time students or permanently disabled to be eligible for coverage. (Attach additional sheets if needed.) Primary Care Physician changes submitted before the 20th of the month will be effective the first of the following month.

02	Spouse's Name (Last) (First) (MI)	Date of Birth	Social Security Number ___-___-____		
	OCI Primary Care Physician Name / Physician Code	Are You a Current Patient? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	Sex ☐ Male ☐ Female	
03	First Eligible Child's Name (Last) (First) (MI)	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number ___-___-____	
	OCI Primary Care Physician Name / Physician Code	Are You a Current Patient? ☐ Yes ☐ No	Student Over 18? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	
04	Second Eligible Child's Name (Last) (First) (MI)	Date of Birth	Sex ☐ Male ☐ Female	Social Security Number ___-___-____	
	OCI Primary Care Physician Name / Physician Code	Are You a Current Patient? ☐ Yes ☐ No	Student Over 18? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	

If enrolling a newborn: Date of discharge from Hospital: _____ **Was this later than the mother's discharge date?** ☐ Yes ☐ No

D. Employee and/or Dependent Removal from Health Plan

Employee's Name (Last) (First) (MI)	Last Day of Coverage	01	Reason Code	Enter reason code(s) in box(es) at left: 1. Changed employment 2. Deceased 3. Dissatisfied 4. No longer eligible 5. Other insurance	
Spouse's Name (Last) (First) (MI)	Last Day of Coverage	02	Reason Code		
Child's Name (Last) (First) (MI)	Last Day of Coverage	03	Reason Code		

E. Conditions of Enrollment

If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Member Services Representative before signing this application.

I hereby apply for membership in the Health Plan for myself and any listed dependents. I have read this application in its entirety, including the Approval to Collect and Disclose Health Information and Enrollment Certifications statement on the other side of this application.

By my signature below, I represent that I understand and agree to all terms and conditions stated in this application, and that all information given by me is accurate, current and complete to the best of my knowledge and belief.

Mandatory Point-of-Service Option: See back of form for disclosure and if you have the right to choose this option. This point-of-service option is provided through **MAMSI Life and Health Insurance Company**. ❑ I choose this option

_____ _____

Signature of Member or Member's representative Date

Printed name of Member or Member's representative: _____

Relationship to the Member and statement of the representative's capacity: _____

_____

_____

Group Authorization Date

OPTIMUM CHOICE, INC.® ("Health Plan")

APPROVAL TO COLLECT AND DISCLOSE HEALTH INFORMATION AND ENROLLMENT CERTIFICATIONS

(This form complies with the requirements of the Health Insurance Portability and Accountability Act of 1996.)

1. Collection of Health Information. I authorize any physician, hospital, or health care provider to furnish the Health Plan with health information, including medical records, claims, benefits and other administrative data that are personally identifiable, about myself and for any eligible dependents listed ("Health Information"), as may be requested by the Health Plan in order to process claims and provide health insurance coverage.

2. Disclosure of Health Information. I also authorize the Health Plan to disclose Health Information as necessary to conduct the Health Plan's business operations relating to the provision of health insurance coverage, including but not limited to developing disease management programs, quality measurements or clinical programs, payment of reinsurance claims, research for measurement purposes such as the development of reimbursements to providers or premium rates for employer groups and for all other purposes related to health care operations. This authorization shall remain in effect for the term of the insurance.

3. I hereby authorize my employer to make any deductions required for my contribution for the monthly premium. I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the Health Plan.

For purposes of this application for insurance, this authorization shall remain effective for a period of thirty months from the date of this authorization, or as otherwise required by law. For the purpose of collecting, disclosing and using information in connection with a claim for benefits, or any other activities of the Health Plan to provide health insurance coverage, this authorization shall remain in effect for the duration of the claim.

I represent that I have the authority to approve the collection and disclosure of Health Information on behalf of all persons enrolled in this health insurance coverage.

Please be advised that you, a person authorized to act on your behalf, or your authorized representative is entitled to receive a copy of this authorization.

MANDATORY POINT-OF-SERVICE OPTION DISCLOSURE STATEMENT

Under Virginia law, if your employer group contract is new or renewing on or after July 1,1998, you may purchase a point-of service option as an additional benefit. You may purchase this additional benefit only if your employer does not concurrently offer another group health benefit plan which provides a point-of-service option. This additional benefit allows you to obtain health care services from physicians and other providers outside the HMO network under certain circumstances that are described in the attached proposal. The point-of-service option is provided through MAMSI Life and Health Insurance Company.

If you select the point-of-service option, you may be responsible for the entire cost of any premium over the amount of the premium applicable to someone who selects coverage offered by Optimum Choice, Inc.® (OCI) without the point-of-service option. Please discuss your cost of the premium with your employer.

If applicable, please indicate your acceptance of the point of service option by checking the appropriate box (listed under Mandatory Point-of-Service Option) on the front of this form. If accepted, please also check the PREFERRED option at the top of the front of this form.