Sentara Health Insurance Company and Sentara Health Plans Enrollment Application

Sentara Health Plans ☐ **Sentara Health Insurance Company**

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

If you are enrolling your spouse or your children, read this first!

The following situations require that you provide additional information or documentation so that your spouse or your children up to age 26 can be enrolled in your health plan. Without this information your enrollment and I.D. cards may be delayed.

Coordination of Benefits

Complete Coordination of Benefits Information Page only if you or any of your enrolling family members over age 26 with an intellectual or physical disability may continue to be eligible for coverage. You may contact Member Services for this form or for additional information.

Continuation of Coverage for Children with an intellectual or physical disability:

Check your application carefully to be sure all birthdays and Social Security numbers are correct.

Please make

Sentara Health Insurance Company
and Sentara Health Plans
1300 Sentara Park
Virginia Beach, VA 23464
(757) 552-7401 (877) 552-7401

Clear Form

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.

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:

Applicant: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital IEMC ET/336 170.04 0d[(H)-2.9 (os)-8 (pi)3.4(ur)-18EMC /P AMCID 94 BDC 0[(P)2.4 .1 (r)-6.B-1./TT0 12 BDC 22 65 (pi)3.1 (t)

SECTION 3

	Date:

Sentara Health Plans and Sentara Health Insurance Company
Large Group (Combined) Enrollment Application

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

To be completed by employer Group No._____ Sub Group No._____
Required **Required, if applicable**

◯ **NEW** ◯ **Open Enrollment** ◯ **Continuation of Coverage** ◯ **C.O.B.R.A.** ◯ **PCP or Address Change**

◯ **Cancel All** ◯ **Add Spouse, Dependent** ◯ **Cancel Spouse, Dependent** ◯ **Reinstatement**

Employer Name Effective/Termination

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Section 11 AUTHORIZATION

I am applying for Sentara coverage for myself and the family members listed. I agree that once enrolled I and my family members will abide by the provisions of coverage in the Group Contract and Evidence of Coverage or Certificate of Insurance under which we will be enrolled. Sentara is the trade name for several different companies including Sentara Health Plans and Sentara Health Insurance Company.

I understand that misrepresentation in answering questions on this application or non-payment of premiums may result in loss of coverage under the Group Health Plan.

I understand that Sentara 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 about me. I understand that I will receive upon request Sentara's complete notice of information collection and disclosure practices.

I authorize any physician, hospital, pharmacy, or other provider of health services or supplies, to disclose to Sentara medical and other information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. This authorioutov(uppl)-8.9 (i)3.1 (es)-8 (,)-1.1 (t)-7Ia-8.1 (t)-13..1120 Td[8 (l)-8.9 (ai)-8.9 (m f)-1.2 (or)-6.3 (b)-12