

# VIRGINIA APPLICATION

OPTIMUM CHOICE, INC.  
A UnitedHealthcare Company

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PREFERRED

MAMSI Life and Health Insurance Company

A UnitedHealthcare Company

- 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: \_\_\_\_\_

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

- HMO  Preferred
- COBRA - First Date on COBRA \_\_\_\_\_

## B. MEMBER INFORMATION

Group Policy Number

Effective Date

Member Number

Social Security Number

**M56541\*20**

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.

0	Spouse's Name (Last) (First) (MI)	Date of Birth	Social Security Number
2	OCI Primary Care Physician Name Physician Code	Are You a Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
0	First Eligible Child's Name (Last) (First) (MI)	Date of Birth	Social Security Number
3	OCI Primary Care Physician Name Physician Code	Are You a Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Student Over 18? <input type="checkbox"/> Yes <input type="checkbox"/> No Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
0	Second Eligible Child's Name (Last) (First) (MI)	Date of Birth	Social Security Number
4	OCI Primary Care Physician Name Physician Code	Are You a Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Student Over 18? <input type="checkbox"/> Yes <input type="checkbox"/> No Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> 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