

**MARYLAND  
SMALL GROUP  
APPLICATION**

**OPTIMUM  
CHOICE®**

A MAMSI Health Plan

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

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 _____		City _____ State _____ ZIP Code _____			
Birth Date	Sex	Previous Membership in OCI? <input type="checkbox"/> Yes <input type="checkbox"/> No		City _____ State _____ ZIP Code _____			
Home Phone ( ) _____	E-Mail Address _____		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		If adding a spouse, please give date of marriage: _____		
Name of Employer _____			Date Employed _____		Business Phone ( ) _____		
Select <b>Your</b> Primary Care Physician _____			Physician Code _____		Are you currently a patient of this Physician? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		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 _____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		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.

Signature of Member or Member's representative \_\_\_\_\_ Date \_\_\_\_\_

Printed name of Member or Member's representative: \_\_\_\_\_

Member representative's 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.
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.
3. I hereby authorize my employer to make 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.