Anthem.

AUTHORIZED INDEPENDENT AGENT

Virginia Medical Plans

Application Instructions for Anthem Blue Cross and Blue Shield of Virginia

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter and application and fax or mail to Virginia Medical Plans for signature. If you do not have access to a fax machine, send the completed application to Virginia Medical Plans along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Select your preferred billing method.
- Sign and date the application.
- Estimated first month's premium must accompany the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Anthem BCBS** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Virginia Medical Plans
Attn: New Enrollment
1404 Northpoint Glen Ct.
Herndon, VA 20170

Virginia Medical Plans will review your application for completeness and accuracy before submiting it to Anthem BCBS for processing. This may reduce the underwritting time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800-867-0800 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

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AUTHORIZED INDEPENDENT AGENT

Virginia Medical Plans

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Virginia Medical Plans
FAX# 888-514-4258

Dear Virginia Medical Plans,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Virginia Medical Plans at 800-867-0800 to verify receipt of my application.

I will send the original application as soon as I have been contacted by Virginia Medical Plans with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Virginia
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross and Blue Shield or HealthKeepers, Inc., premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 330-1108.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the Initial Open Enrollment is January 1, 2014. For applications received after December 15, 2013, the Effective Date for the initial Open Enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20th, your effective date is March 1st).

Applications must be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Notice of a qualifying event must be received by HealthKeepers, Inc. within 60 days of the qualifying event.

Qualifying Events

Please check the qualifying event:

- ☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- ☐ Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;
- ☐ Marriage/Domestic Partnership;
- ☐ Adoption or placement for adoption or appointment of guardianship;
- ☐ Birth.

Please provide the date of the qualifying event: _____

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)			

City	State	ZIP	County

Billing Address (street and P.O. Box if different from above)		

City	State	ZIP

Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth / /

Primary Phone Number ( )	Secondary Phone Number ( )	E-mail*

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner

Social Security Number*	Sex ☐ M ☐ F	Date of Birth / /

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or children of your spouse, including newborn children, stepchildren, legally adopted children, and legal guardianships (to the end of the calendar month in which they turn age 26). A subscriber has the option to cancel dependent coverage effective on the next available date after notice is received by HealthKeepers, Inc. Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the subscriber or subscriber's spouse. (List all dependents beginning with the eldest).

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number*	Relationship to Applicant
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No

If **NO**, who? _____

Are all applicants listed on this application United States citizens, nationals or lawfully present non-citizens? ☐ Yes ☐ No

If **NO**, who? _____

Has any applicant used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No

If **YES**, who? _____

Preferred written language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Preferred spoken language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Section E – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select ONE Plan…then select ONE Individual Deductible/Coinsurance option.
Total Family Deductible is two (2) times the amount shown.

☐ **Anthem HealthKeepers Core DirectAccess**

- ☐ $4,500/35% cabw-(0RUR)
- ☐ $5,500/25% caam-(0RUM)

☐ **Anthem HealthKeepers Core DirectAccess with Bariatric Surgery**

- ☐ $4,500/35% cacb-(0RUZ)
- ☐ $5,500/25% caab-(0RUV)

☐ **Anthem HealthKeepers Core DirectAccess with Child Dental**

- ☐ $4,500/35% cdbw-(0RV3)

☐ **Anthem HealthKeepers Core DirectAccess with Child Dental and Bariatric Surgery**

- ☐ $4,500/35% cdab-(0RV5)

☐ **Anthem HealthKeepers Essential DirectAccess**

- ☐ $1,500/30% cbky-(0RVN)
- ☐ $2,250/20% cbjs-(0RVH)
- ☐ $2,600/20% cbfs-(0RVC)
- ☐ $3,350/15% cbau-(0RV7)

☐ **Anthem HealthKeepers Essential DirectAccess with Bariatric Surgery**

- ☐ $1,500/30% cbmb-(0RW8)
- ☐ $2,250/20% cbib-(0RW3)
- ☐ $2,600/20% cbeb-(0RVY)
- ☐ $3,350/15% cbab-(0RVT)

☐ **Anthem HealthKeepers Preferred DirectAccess**

- ☐ $750/20% ccam-(0RWD)

☐ **Anthem HealthKeepers Preferred DirectAccess with Bariatric Surgery**

- ☐ $750/20% ccab-(0RWF)

☐ **Anthem HealthKeepers Preferred DirectAccess with Child Dental**

- ☐ $750/20% cdda-(0RWH)

☐ **Anthem HealthKeepers Preferred DirectAccess with Child Dental and Bariatric Surgery**

- ☐ $750/20% cdeb-(0RWK)

☐ **Anthem HealthKeepers Catastrophic DirectAccess** (only available for Applicants under age 30 or otherwise qualified)

☐ $6,350/0% cmaa -(0RWM)

☐ **Anthem HealthKeepers Catastrophic DirectAccess with Bariatric Surgery** only available for Applicants under age 30 or otherwise qualified)

☐ $6,350/0% cmab -(0RWP)

HSA Plans

☐ **Anthem HealthKeepers Core DirectAccess with HSA**

☐ $3,750/25% cacd-(0RUT) ☐ $6,000/15% caas-(0RUP)

☐ **Anthem HealthKeepers Core DirectAccess with HSA and Bariatric Surgery**

☐ $3,750/25% cadb-(0RV1) ☐ $6,000/15% cabb-(0RUX)

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to HealthKeepers, Inc.'s banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to HealthKeepers, Inc.'s banking partner.

Section F – Dental Coverage

☐ **Yes, I wish to add dental coverage (at an extra cost per individual)**

Select ONE plan below:

☐ Anthem Dental Pediatric	☐ Anthem Dental Adult	☐ Anthem Dental Family
☐ Anthem Dental Pediatric Enhanced	☐ Anthem Dental Adult Enhanced	☐ Anthem Dental Family Enhanced

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only	☐ Applicant & all dependent children listed
☐ Applicant & Spouse or Domestic Partner only	☐ Applicant, Spouse or Domestic Partner, and all dependent children listed
	☐ All dependent children listed

Important: You must enroll in pediatric dental coverage unless you will be enrolled in a standalone dental plan that has been certified by a state Exchange. To determine if your standalone dental plan has been certified by a state Exchange, please refer to your health plan enrollment information or the website for your state Exchange.

☐ Please check if you will be enrolled in a standalone dental plan meeting this requirement.

Section [G] – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

If **YES**, who and reason:

_____

_____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for HealthKeepers, Inc. coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although HealthKeepers, Inc. requires payment with my application, sending my initial premium with this application, and the receipt of my payment by HealthKeepers, Inc., does not mean that coverage has been approved. I may not assign any payment under my HealthKeepers, Inc. program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, HealthKeepers, Inc. reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify HealthKeepers, Inc. of any change that would make me or any dependent ineligible for coverage.
- I understand HealthKeepers, Inc. may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any HealthKeepers, Inc. automatic debit process and will only occur each time I send a check to HealthKeepers, Inc. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between HealthKeepers, Inc. and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is at least 18 years of age; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- ☐ By checking this box, I authorize and expressly consent that HealthKeepers, Inc. and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting HealthKeepers, Inc. customer service or online at www.anthem.com.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by HealthKeepers, Inc. in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by HealthKeepers, Inc.. I am acting as their agent and representative.

This application shall be altered solely by the applicant or with his or her written consent.

SIGN HERE		
	Signature of Applicant* or Legal Representative X	Date
	Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
	Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your HealthKeepers, Inc.-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? ☐ Yes ☐ No

If **NO**, please explain: _____

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature X				Date
Agent/Broker Name (please print) Jonathan Katz		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. 1404 Northpoint Glen Court		
Agent/Broker ID/TIN 228210944	Agency ID/Parent TIN A00494-0258	City Herndon	State VA	ZIP 20170
Agent/Broker Phone No. 800-867-0800	Agent/Broker Fax No. 888-514-4258	Agent/Broker E-mail jkatz@vamedicalplans.com		
GA (if applicable) EBCA		GA code (if applicable)		

Authorization for Use of Protected Health Information

By signing below: I authorize HealthKeepers, Inc., or an agent/broker, subsidiary or affiliate that has a business associate contract with HealthKeepers, Inc., to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations for the purpose of collecting information in connection with administration of benefits.

This authorization is subject to revocation at any time by written notice to HealthKeepers, Inc. except to the extent that HealthKeepers, Inc. has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

Unless previously revoked, this authorization is valid for 24 months from the date of signature.

SIGN HERE			
	Printed name of Applicant/Member X	Signature of Applicant/Member or his/her Legal Representative X	Date
	Printed name of Spouse or Domestic Partner or Dependent Child* age 18 or over listed on Application X	Signature of Spouse or Domestic Partner or Dependent Child* or his/her Legal Representative X	Date
	Printed name of Dependent Child* age 18 or over listed on Application X	Signature of Dependent Child* or his/her Legal Representative X	Date

**If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above.*
If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.
A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.

Offered by HealthKeepers, Inc.

Please mail this application to the following address:

Anthem Blue Cross and Blue Shield

P.O. Box 9041

Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 848-2512

Payment Methods for Individual Applications – Virginia

Anthem HealthKeepers

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

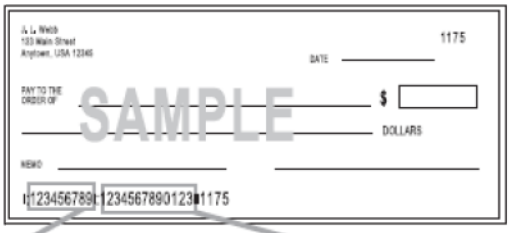
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem which you are notified pursuant to your plan/policy. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **You will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem Blue Cross and Blue Shield which you are notified pursuant to your plan/policy. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa and MasterCard.**

Card Number:	Expiration Date:	
Billing address for this Credit / Debit Card:	**City:**	**Zip Code:**

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval and you will not receive your check back from your financial institution.