VIRGINIA MEDICAL PLANS
FAMILY & BUSINESS HEALTH INSURANCE

Anthem
AUTHORIZED INDEPENDENT AGENT

Application Instructions for Anthem Blue Cross and Blue Shield of Virginia

1. This application contains fillable fields. When viewed with Adobe Reader the form can be completed on your computer and then printed. Please be sure to complete all questions and sections of the application before printing.
2. f you prefer to complete the form by hand, print the blank pages and then complete all questions and sections.
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 underwriting time because Anthem 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 703-707-8270 or toll free at 888-396-2341 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

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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 703-707-8270 or toll free at 888-396-2341 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

Virginia
Individual Dental and Vision 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 (Anthem), 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._____

Enrollment

You may apply for coverage at any time during the year. Your Effective Date will be the first day of the following month after receipt of your application and premium. **Your benefit and enrollment elections are intended to remain the same until your renewal date. For existing plan members, changes to your coverage can only be made at your renewal date, unless you have a qualifying event as defined below. Notice of a qualifying event must be received by Anthem Blue Cross and Blue Shield within 60 days of the qualifying event.** In the case of a future Loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 60 days in advance of the qualifying event date.

Qualifying Events for Existing Members

Please check the qualifying event:

☐ Loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;

☐ Changes in your spouse's or domestic partner's employment, such as starting/losing a job or a change in the number of hours worked;

☐ Marriage/Domestic Partnership;

☐ Birth, adoption or placement for adoption or appointment of guardianship;

☐ Covered children reach the limiting age of the Policy.

☐ Moved to a new exchange service area;

☐ Released from incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Renewal of non-calendar health plan coverage; or

☐ Other Qualifying Event: _____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events.)

Please provide the date of the qualifying event checked above: _____

Coverage Effective Dates for Qualifying Events

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 or court ordered coverage including child support order, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship or the mandated effective date within the court order; or
- In the case of marriage/domestic partnership, loss of Minimum Essential Coverage, release from incarceration, death of a family member under your current coverage or renewal of non-calendar health plan 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			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable			
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.*

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.*

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 are no longer a dependent as defined by the policy). A subscriber has the option to cancel dependent coverage by written notice delivered or mailed to us, effective upon receipt or on such later date as may be specified in such notice. 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. (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.*

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges) ☐Yes ☐No

If YES, who?_____

Preferred written language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Preferred spoken language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Section E – Dental Coverage

Select your plan option:

These plans *include* pediatric dental Essential Health Benefits.

☐ Anthem Dental Pediatric – 1FVJ ☐ Anthem Dental Family – 1FVK ☐ Anthem Dental Family Enhanced – 1FVL

These plans do *not* include pediatric dental Essential Health Benefits that are required by the Affordable Care Act. You must have another dental plan (see above plans) or medical plan that has the pediatric dental Essential Health Benefits.

☐ Dental Prime Plan A – 1RCJ ☐ Dental Prime Plan B – 1RCK ☐ Dental Prime Plan C – 1RCL

Section F – Other Dental Coverage

Do you, or anyone applying for coverage, currently have dental 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

If approved, will this Anthem dental coverage replace any other dental coverage? ☐ Yes ☐ No

If **YES**, what is the date your other coverage will end? _____

Note: You cannot be covered by more than one Anthem individual dental policy at the same time.

Section G – Vision Coverage

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in one of the dental coverage options, except for Anthem Dental Pediatric, in this application. If you have enrolled in one of the dental plans above and would like to add vision coverage, please select your plan option below.

☐ Blue View Vision – 1RYB*

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

*This plan does not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.

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

Please read this section carefully before signing the application.

- I understand that although Anthem Blue Cross and Blue Shield requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem Blue Cross and Blue Shield, does not mean that coverage has been approved. I may not assign any payment under my Anthem Blue Cross and Blue Shield program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem Blue Cross and Blue Shield 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 Anthem Blue Cross and Blue Shield of any change that would make me or any dependent ineligible for coverage.
- I understand Anthem Blue Cross and Blue Shield 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 Anthem Blue Cross and Blue Shield automatic debit process and will only occur each time I send a check to Anthem, Blue Cross and Blue Shield. 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 Anthem Blue Cross and Blue Shield and myself.
- I understand I am applying for individual dental or individual dental and vision 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 is at least 18 years of age; he or she is mentally competent; he or she is not related by blood closer than permitted under applicable State marriage laws; he or she is not married and does not have any other domestic partners; share a residence; and he or she is financially interdependent with me.
- ☐ By checking this box, I authorize and expressly consent that Anthem Blue Cross and Blue Shield 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 Anthem Blue Cross and Blue Shield 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 Anthem Blue Cross and Blue Shield in accepting this application. Any fraudulent misstatements found in this application may result in denial of benefits or cancellation of my coverage(s), subject to the Time Limit on Certain Defenses provision of the policy, which states after you have been insured under the policy for 2 consecutive years, only fraudulent misstatements in the application may be used to either void the policy or to deny a claim for any covered services incurred after the expiration of such 2 year period.
- I certify each social security number listed on this application is correct.
- **The undersigned applicant and agent , if applicable, certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy**.
- **I understand that the Dental Prime plans, Family and Family Enhanced plans have waiting periods.**

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross and Blue Shield. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

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 Anthem Blue Cross and Blue Shield-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 A00494-0258	Agency ID/Parent TIN 47-2708150	City Herndon	State VA	ZIP 20170
Agent/Broker Phone No. (703) 707-8270	Agent/Broker Fax No. (888) 514-4258	Agent/Broker E-mail jkatz@vamedicalplans.com		
GA (if applicable) EBCA	GA code (if applicable) 54-2015926			

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.