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

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Virginia
Individual Enrollment Application

Medical coverage plans made available under this application are health maintenance organization products offered by HealthKeepers, Inc. Supplemental Dental and Vision Plans are offered by Anthem Blue Cross and Blue Shield.

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 and 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 annual Open Enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still apply for a health plan if he/she experiences a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. 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.

No qualifying event is required to apply for new dental coverage.

For existing dental plan members, dental coverage changes and/or addition of dependents may only occur during the Open Enrollment period or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.

Please indicate the reason you are submitting this application:

☐ Open Enrollment Period
☐ Special Enrollment Period

If Special Enrollment Period, please provide the qualifying event date, qualifying event and, if applicable, the coverage effective date:

1. **Date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage):

   _____

2. 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;
☐ Birth or adoption or placement for adoption or appointment of guardianship;
☐ Placement in foster care;
☐ Moved to a new exchange service area or immigration status changed to lawfully present;
☐ Released from incarceration;
☐ Death of a family member enrolled under your current coverage;
☐ Renewal of non-calendar year health plan coverage;
☐ Court ordered coverage including child support order;
☐ 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).

3. Coverage Effective Date:

If you are applying due to a qualifying event and your application is processed, your coverage effective date will be based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month. **However the following qualifying events allow for different effective dates:**

- In the case of marriage, domestic partnership, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

For the following qualifying events, select one of the effective date options as described in the chart below.

- In the case of birth, or adoption, or placement for adoption, or placement in foster care, or appointment of guardianship; ☐ A ☐ B ☐C ☐D
- In the case of court ordered coverage including child support order; ☐ A ☐C
- In the case of death of a family member enrolled under your current coverage; ☐ B ☐C

Effective date options

A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or placement in foster care, or appointment of guardianship, or date of court order.
B	First day of the month following receipt of your application.
C	Based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.
D	First day of the month following the date of the qualifying event.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number* (required)
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	

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth	

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). 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* (required)	Relationship to Applicant
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____

**HealthKeepers, Inc. is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

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 present non-citizens? ☐ Yes ☐ No

If **NO**, who? _____

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

If **YES**, who? _____

Has any applicant used tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial usage)? ☐ 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.

The service area for the plans referenced below is all of Virginia, excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.

☐ Anthem HealthKeepers Bronze
- ☐ $4,650/35% -(1GB9)
- ☐ $5,500/25% -(1GB8)

☐ Anthem HealthKeepers Bronze POS
- ☐ $4,100/30% -(1GBA)

☐ Anthem HealthKeepers Silver
- ☐ $1,550/30% -(1GBG)
- ☐ $2,250/20% -(1GBE)
- ☐ $2,600/20% -(1GBD)
- ☐ $3,350/15% -(1GBC)

☐ Anthem HealthKeepers Silver POS
- ☐ $2,000/20% -(1GBF)

☐ Anthem HealthKeepers Gold
- ☐ $750/20% -(1GBJ)

☐ Anthem HealthKeepers Gold POS
- ☐ $1,100/15% -(1GBH)

☐ Anthem HealthKeepers Catastrophic (only available for Applicants under age 30 or otherwise qualified)
- ☐ $6,850/0% -(1GB6)

HSA Plans

☐ Anthem HealthKeepers Bronze 15% for HSA -(1GB7)
☐ Anthem HealthKeepers Bronze 35% for HSA -(1GBB)
☐ Anthem HealthKeepers Bronze 50% for HSA -(1X4X)
☐ Anthem HealthKeepers Bronze POS 0% for HSA -(1X55)

☐ **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. 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. banking partner.

Section F – Dental and Vision Coverage

Dental

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits available to enrollees to the end of the month they turn age 19 which are included in the medical plans above.**

Select ONE Plan:

☐ **Anthem Dental Family** -(1FVK)
☐ **Anthem Dental Family Enhanced** -(1FVL)
☐ **Dental Prime Plan A*** -(1RCJ)
☐ **Dental Prime Plan B*** -(1RCK)
☐ **Dental Prime Plan C*** -(1RCL)

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

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

*These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.

Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual*** -(1RYB)

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

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

*These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.

Section G – Other Health and Dental Coverage

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

   If **YES**, who? _____

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

Compensation benefits?

If **YES**, who and reason:

_____
_____
_____

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

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

If **YES**, please provide the following for health coverage:

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 replacing this health coverage if approved for HealthKeepers, Inc. coverage? ☐ Yes ☐ No	If **YES**, what is the termination date?

4) Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental coverage:

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 replacing this dental coverage if approved for Anthem Dental coverage? ☐ Yes ☐ No	If **YES**, what is the termination date?

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 and HealthKeepers, Inc. 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 and HealthKeepers, Inc., does not mean that coverage has been approved. I may not assign any payment under my Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. 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 and 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 Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. of any change that would make me or any dependent ineligible for coverage.
- I understand Anthem Blue Cross and Blue Shield and 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 Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. automatic debit process and will only occur each time I send a check to Anthem Blue Cross and Blue Shield and 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 Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. and myself.
- I understand I am applying for individual health and/or dental/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 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 Anthem Blue Cross and Blue Shield and 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 Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. customer service or online at www.anthem.com.
- I certify to the best of my knowledge and belief, the responses herein are accurate. I certify that I have read, or had read to me, the completed application and that I realize that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact in the application may result in the denial of benefits, rescission or cancellation of coverage(s).
- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. 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 and 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. I certify that the applicant has read, or had read to him/her, the completed application and that the applicant realizes that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact in the application may result in the denial of benefits, rescission or cancellation of coverage(s).

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) Employee Benefits Corporation of America		GA code (if applicable) 54-2015926		

And Its Affiliate 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) 327-9255

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)

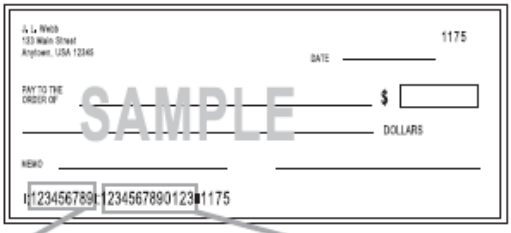
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ 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.