VIRGINIA MEDICAL PLANS
FAMILY & BUSINESS HEALTH INSURANCE

Anthem.
AUTHORIZED INDEPENDENT AGENT

Application Instructions for Anthem Application - 2017

1. Please print all pages of the application including instructions
2. Complete all questions and sections of the applicaton. Please write legibly.
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 (see IMPORTANT info below).
- Sign and date the application.
- Estimated first month's premium must accompany the application.

IMPORTANT:

Please be sure to complete the Payment Methods page (after page 8). You must choose either Option 1 or Option 2.

If you choose Option 1, your initial and subsequent payments will occur through monthly EFT - please provide complete bank information in Section A.
If you choose Option 2, select the method for your initial payment, and you will receive a bill every month thereafter. Please note, Anthem does not allow automatic credit card payments for subsequent payments.

Be sure to sign where indicated on the payment page.

It is best to fax or scan your completed application to us. However if you prefer to mail it please be sure to allow ample time for processing:

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 for processing. This may reduce the approval 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 703-707-8270 or toll free at 888-396-2341 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

VIRGINIA MEDICAL PLANS
FAMILY & BUSINESS HEALTH INSURANCE

Anthem

AUTHORIZED INDEPENDENT AGENT

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.

Primary applicant name: _____

Welcome

Virginia Individual Application

Thanks for choosing us. We're glad you're here.
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.

If you have any questions while filling out this form, give us a call at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first. Jonathan Katz / Virginia Medical Plans 703-707-8270 or 888-396-2341

About this form

Use this form to apply for **new** medical, dental or vision coverage or to **change** existing coverage with Anthem Blue Cross and Blue Shield.

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   The earliest your coverage can start is the 1st of the year. Your coverage will start based on when we receive your complete application (including payment). If we get it:
   - Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
   - Between the 16th and last day of the month, coverage is effective the 1st day of the second following month.
2. **Due to a qualifying event** (such as getting married, having a baby, etc.)
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about when coverage starts.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. You can also apply online at anthem.com. Call us to apply online 703 707 8270
3. Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.

Some Frequently asked questions

1. **Do I need to include a payment?**
   Yes. We can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check until you've been enrolled.
2. **What if I already have coverage with another company?**
   Don't cancel your other coverage yet – your health coverage is too important. We'll contact you when you're approved. Then you'll need to cancel your other coverage.
3. **Why do you need my Social Security Number?**
   The IRS requires us to collect it. It won't be shared unless required by law. If you enroll in a health savings account (HSA) compatible plan with us, we'll give it to our HSA banking partner.

Step 1: Who is applying?

Primary Applicant ☐ New coverage ☐ Change coverage ☐ Add dependent to existing coverage ID No. _____

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security No.

Marital status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of VA: ☐ Y ☐ N US Citizen or National: ☐ Y ☐ N	County (for home address)	Tobacco use* ☐ Yes ☐ No

Home address	City	State	ZIP
Billing address (optional - if different than your home)	**City**	**State**	**ZIP**
Mailing address (optional - if different than your home)	**City**	**State**	**ZIP**

Primary phone	Secondary phone	Email address

Preferred written language ☐ English (ENG) ☐ Spanish (SPA) **Preferred spoken language** ☐ English (ENG) ☐ Spanish (SPA)

Spouse or Domestic partner

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security No.

Relationship to applicant ☐ Spouse ☐ Domestic partner	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of VA ☐ Yes ☐ No	US Citizen or National ☐ Yes ☐ No	Tobacco use* ☐ Yes ☐ No

Child dependent Children must be under 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.

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security No.

Relationship to applicant ☐ Child ☐ Other _____	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of VA ☐ Yes ☐ No	US Citizen or National ☐ Yes ☐ No	Tobacco use* ☐ Yes ☐ No

Child dependent

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security No.

Relationship to applicant ☐ Child ☐ Other _____	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of VA ☐ Yes ☐ No	US Citizen or National ☐ Yes ☐ No	Tobacco use* ☐ Yes ☐ No

Child dependent ☐ **Check here if you have more dependents**. Print an extra copy of this page and attach to your application.

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security No.

Relationship to applicant ☐ Child ☐ Other _____	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of VA ☐ Yes ☐ No	US Citizen or National ☐ Yes ☐ No	Tobacco use* ☐ Yes ☐ No

*Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Eligibility

Are any applicants eligible for Medicare?
☐ No ☐ Yes **If yes, who?**

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)
☐ No ☐ Yes **If yes, who?**

Are any applicants currently receiving Social Security Disability, Medicare or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits?
☐ No ☐ Yes **If yes,** fill out the boxes below.

Who	Reason	Start date of benefits	End date of benefits

Step 2: What coverage would you like?

Medical Plans

Choose only one medical plan.

Our plans are available in all of Virginia, excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.

Anthem HealthKeepers Bronze	Anthem HealthKeepers Silver	Anthem HealthKeepers Gold
☐ POS 4500 (1GBA) ☐ 4900 for HSA (1GBB) ☐ 5150 (1GB9) ☐ POS 5750 for HSA (1X55) ☐ 5900 (1GB8) ☐ 6200 for HSA (1GB7) ☐ 6350 (2EUK)	☐ 1800 (1GBG) ☐ POS 2300 (1GBF) ☐ 2800 (1GBD) ☐ 3500 (1GBC) ☐ 5000 (2EUL)	☐ 1000 (1GBJ) ☐ 1300 (2ETV)

Anthem HealthKeepers Catastrophic

☐ 7150 (1GB6)

Health Savings Account (HSA) Enrollment If you chose an HSA compatible plan, you have the option to setup a health savings account.

☐ Yes, I'd like to establish an HSA with HealthKeepers, Inc. banking partner. (Please make sure you entered Social Security numbers in Step 1)

Current (existing) medical coverage

If you already have health care coverage, please don't cancel it until you are effective with us.

☐ One or more of the applicants currently have health care coverage (Please fill out the info below)

People with coverage (Write ALL if everyone)	**Existing health care coverage company**	**Effective date** (When coverage started)
Type of coverage ☐ Group ☐ Individual	**ID number(s)**	**Last date of coverage** (If applicable)
Will you be replacing this health coverage if approved for Healthkeeper's Inc. coverage? ☐ Yes ☐ No		If **Yes,** what is the termination date?

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a dental plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan option	**Existing dental coverage** It's important we know.	
☐ Anthem Dental Family Value (2J5G) ☐ Anthem Dental Family (1FVK) ☐ Anthem Dental Family Enhanced (1FVL) ☐ Dental Prime A (1RCJ) ☐ Dental Prime B (1RCK) ☐ Dental Prime C (1RCL)	☐ I currently have dental coverage (please fill out the info below)	
	People with coverage (write ALL if everyone applying):	
	Existing dental coverage company:	**Effective date** (when this coverage started)
	ID Number:	**Last date of coverage** (if applicable)

Applicants for dental plan	Check all that apply (Primary applicant must be included)
☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children	
Will you be replacing this dental coverage if approved for Anthem's coverage? ☐ Yes ☐ No	If **Yes,** what is the termination date?

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

Vision Plan

You must enroll in medical and/or dental coverage to be eligible for vision coverage.

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan option	**Existing vision coverage** It's important we know.	
☐ Blue View Vision Individual (1RYB)	☐ I currently have vision coverage (please fill out the info below)	
	People with coverage (write ALL if everyone applying):	
	Existing vision coverage company:	**Effective date** (when this coverage started)
	ID Number:	**Last date of coverage** (if applicable)

Applicants for vision plan	Check all that apply (Primary applicant must be included)
☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children	
Will you be replacing this vision coverage if approved for Anthem's coverage? ☐ Yes ☐ No	If **Yes,** what is the termination date?

Step 3: Please read and sign

Important legal information

I understand that:

- I must send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. If my application is denied, my bank account or credit card will not be charged.
- I'm responsible to let Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.

- Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge 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. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- 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'm applying for individual health and/or dental and/or vision coverage which is not part of any employer sponsored plan. I certify that neither I nor any dependent is being reimbursed or compensated for this coverage by any employer. I'm responsible for all of the premium payments and making sure that all premiums are paid.
- By signing below, I (primary applicant) agree to receive my policy, certificate or evidence of coverage electronically. I know that at any time I can change my mind and request a free copy of these materials by mail, by contacting Anthem Blue Cross and Blue Shield and HealthKeepers, Inc..
- I certify that each Social Security number listed on this application is correct.
- 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.
- 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 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 Blue Cross and Blue Shield and HealthKeepers, Inc. absent the acknowledgement and consent of Anthem Blue Cross and Blue Shield and HealthKeepers, Inc..

Please sign below

	Primary Applicant (or legal representative)	Date
	Spouse or Domestic Partner (or legal representative)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date

Did an agent help you? Make sure they fill out this section.

Agent (or broker) Certification

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		**Date**	
Agent Name (Please print clearly) Jonathan Katz	**Agent TIN / SSN** (Encrypted TIN is ok) GDGKGSSMNZ	**Agency or Parent TIN/ID** JDKHMSLKQY	
Agent Address 1404 Northpoint Glen Court	**City** Herndon	**State** VA	**ZIP** 20170
Agent Phone No. (888) 396-2341	**Agent Fax No.** (703) 783-5913	**Agent Email** Jkatz@vamedicalplans.com	

Here's what's next.

1) Can you check a few items? When incorrect, they're the most frequent reasons for delays in enrollment.
   - Your name and address information should be clear and readable
   - You've included your first month's premium payment
   - Everyone 18 and older signed this form
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 9041, Oxnard, CA 93031-9041 or by fax to 1 (800) 327-9255.

Return to Virginia Medical Plans

3) We'll be in touch in the next few weeks. If you have questions before then, call us at 1 (855) 330-1108.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
☐ **1. Marriage or Domestic Partnership** Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility)	First day of the month after we receive your complete application.
☐ **2. Birth or Adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court Order or Guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order, appointment of guardianship of a child or a child in foster care is placed with you	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Other qualifying event** If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law	Based on when we receive your complete application*

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
7. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move	First day of the month after we receive your complete application
☐ **8. Permanent Move** Moved to U.S. from a foreign country or a U.S. territory ☐ **9. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **10. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application.*

* If the coverage date is based on when we receive your application then if we receive it:

- Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

Almost there! We need a bit more info.

We need supporting documentation for your qualifying event, such as a letter or official form from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. If you're applying because you've lost your coverage, we need to know the reason why coverage was lost, and it must be included in the supporting documentation. In all instances, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Payment Methods for Individual Applications – Virginia

Anthem BlueCross BlueShield
And Its Affiliate HealthKeepers, Inc.

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.

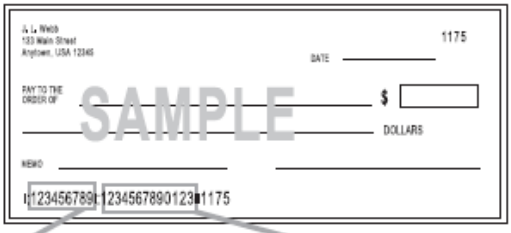
☐ Monthly Automatic Premium Payment (complete Section A)

☐ **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.

Get help in your language

Language Assistance Services

Anthem BlueCross BlueShield
And Its Affiliate HealthKeepers, Inc.

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1810). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1810). (TTY/TDD: 711)

Amharic
ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (855-748-1810) በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ። (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1810). (TDD/TTY: 711)

Bassa
Ɔ jŭ ké m̀ dyi gbo-kpá-kpá mɔ́ bé m̀ ké céè-dɛ nìà kɛ múin wɔ dé bà-wɛĭn wùdù dò mú ní, m̀ bɛ́ìn ɔ zɔ̀ɔ̀ dyììn dé Mɛ́bà jè gbo-gmɔ̀ Kpòè nɔ̀bà nìà kɛ <855-748-1810> dá dá mú. M̀ se wídí kàkò dò pɛ́ĭn m. (TTY/TDD: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1810)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1810)請求免費協助。(TTY/TDD: 711)

Farsi
در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضاء به شماره (855-748-1810) تماس بگیرید. (TTY/TDD: 711)

French
Si vous avez besoin d’aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1810. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-748-1810). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-748-1810) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Igbo
Ọ bụrụ na ị chọrọ enyemaka iji ghọta dọkụmentị a n’asụsụ dị iche, ị nwere ike ịrịọ ya na akwụghị ụgwọ ọ bụla ọzọ site na ịkpọ nọmba Ọrụ Onye Otu (855-748-1810). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1810)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1810). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1810). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو
جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کرکے اس کی درخواست کرسکتے ہیں
(711:TDD/TTY) (855-748-1810)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-748-1810). (TTY/TDD: 711)

Yoruba
Tí o bá nílò ìrànwọ́ kí àkọsílẹ̀ yìí le yé ọ ní èdè míràn, o le bèrè rẹ̀ láìsí àfikún owó nípa pípe Nọ́mbà Àwọn ìpèsè ọmọ-ẹgbẹ́ (855-748-1810). (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Information for Applications Requesting a Special Enrollment Period

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

When applying to enroll for coverage during a Special Enrollment Period, an applicant must be eligible to enroll and provide supporting documentation of a qualifying event. Without this documentation the applicant may not be able to enroll.

Please review the list below which outlines examples of what may be used as supporting documentation. Be sure to send in a copy of the documentation supporting the qualifying event when the completed application is submitted or upload a copy of the documentation when submitting an online application.

For paper applications, please submit legible copies of everything and keep all original documents for your personal records, because no documentation will be returned. Please write the applicant's name on the top of each page of the supporting documentation.

After reviewing the information provided, we may request additional documentation to confirm eligibility. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay a premium do not constitute qualifying events.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or customer service at 1-855-330-1108.

Supporting Documentation by type of qualifying event
OFF Exchange for all SEP applicants for a HealthKeepers plan

Qualifying event	Description and examples of supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to change in employment status:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals) and reason for loss of minimum essential coverage (i.e., reduction in employment hours, etc.), **or** • Letter that provides notice of **offer** of COBRA or state continuation benefits. **Loss of Minimum Essential Coverage due to loss of dependent eligibility status:** **Due to death:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals), and • Copy of death certificate or obituary **Due to Medicare eligibility:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals), and • Copy of Medicare card or approval letter from Social Security **Due to an over-age dependent:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals) **Due to legal separation, divorce, dissolution of domestic partnership:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals), and • Divorce decree, legal separation agreement, or notarized/legal termination of domestic partnership

Qualifying event	Description and examples of supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to exhaustion of COBRA or state continuation benefits:** • Letter that provides notice of termination of COBRA or state continuation benefits. **Loss of Minimum Essential Coverage due to (permanent) move to new service area:** *Note: Applicant must have had Minimum Essential Coverage for one or more days in the 60 days prior to the permanent move, unless he or she is moving from a foreign county or a United States territory (See below).* • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) **and** • Documentation of applicant's old address and new address (if not present on employer letter or previous carrier documentation) which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage or nursing home/assisted living facility residency documentation — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license, vehicle registration, or change of address card — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — U.S. Postal Service change of address confirmation letter — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — Document from the Department of Corrections, jail, or prison indicating recent release or parole, including an order of parole, order of release, or an address certification — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend, or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address. The supporting documentation needs to include the name of the applicant along with the residential address listed on the application (the new address), and documentation of the previous address, which should include the applicant's name and the residential address before the move. For **child only applications**, the name of the parent/guardian in the signature section of the application must match the name on the supporting documentation.

Qualifying event	Description and examples of supporting documentation
Legal guardianship or court order	Legal documentation of guardianship that indicates the subscriber or the subscriber's spouse is a guardian of the applicant or court order that indicates the subscriber is required to cover the applicant. Contact us if you are applying for a child only policy.
Gain or become a dependent through birth or adoption/ placement for adoption	**Birth:** Birth certificate **or** medical records from hospital or pediatrician which indicate the names of the parents, the name of the baby and date of birth. *NOTE: For current HealthKeepers members, a mother's delivery claim may be considered as proof.* **Adoption/placement for adoption:** Adoption certificate or document establishing placement of a child with applicant for adoption.
Gain a dependent through marriage or domestic partnership	Certificate of marriage, domestic partnership
Applicants moving to the U.S. from a foreign country or U.S. territory	∘ Documentation of the move (including date of move) which may be validated by a passport or VISA, **and** ∘ Documentation of the new address which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license or vehicle registration — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend, or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address.
Release from incarceration	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge.
Child declined for Medicaid coverage	Documentation showing that the application for Medicaid coverage occurred during the annual open enrollment period and copy of Medicaid decline letter dated within 60 days.

Qualifying event	Description and examples of supporting documentation
An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status	Change in status validated by any of the following: • Valid U.S. passport or passport card. • Valid I-551, permanent resident card (issued by the Department of Homeland Security/ U.S. citizenship and immigration services). Non-expiring I-551 (issued 1977-1989) cards are acceptable. • U.S. Certificate of Naturalization (federal form N-550). • Certificate of U.S. Citizenship (federal form N-560). • Employment Authorization Document. • Unexpired foreign passport with a valid unexpired U.S. visa affixed accompanied by the approved I-94 form documenting the applicants most recent admittance into the U.S.
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events	An official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected.