innovation HEALTH
Aetna | Inova PARTNERSHIP

Virginia Medical Plans

Application Instructions for Innovation Health / Aetna Northern Virgina

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

HELPFUL TIPS:

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

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

IMPORTANT:

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

Don't forget to **enclose a check for the required payment made payable to Innovation Health** 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 Innovation Health for processing. This may reduce the underwritting time because they cannot process unclear or incomplete applications until the missing information has been gathered.

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

Norvax form #IN-1

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Virginia Medical Plans

FAX COVER LETTER

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

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

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

Name ____

E-mail ____

Date ____

Time ____

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

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

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

Norvax form #CS-1

Virginia
Application for Innovation Health Insurance

Innovation Health Insurance Company

The following counties and cities are eligible for Innovation Health Insurance Plans:
Alexandria, Arlington, Fairfax, Fairfax, Falls Church, Loudoun

Corporate Address: Innovation Health Insurance Company
3130 Fairview Park, Suite 300
Falls Church, Virginia 22042

Primary Applicant's Name

Applicant's Social Security Number								

INSTRUCTIONS:

- **Please complete in blue or black ink only. PRINT clearly.**
- **The information you provide is confidential.**
- **All answers must be complete and truthful.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Applications for coverage must be submitted during.**
  - ➢ **Annual Open Enrollment Period – October 1, 2013 through March 31, 2014**
    If applying during this period, check the box in Section C below.
  - ➢ **Special Enrollment Periods – If applying outside of Annual Open Enrollment Period see Section D.**

Section A – Primary Applicant Information

Primary Applicant Last Name	First Name	Middle Initial
Home Address (No PO Boxes)		Apt. Number
City	State	ZIP Code
Mailing Address (If different from your Home address)		
City	State	ZIP Code
County	E-mail Address	
Telephone Number **Primary** (_____)____________________ **Secondary** (_____)____________________	If we need to call you with any question about your application, when is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening	

Section B – Coverage Information

Application Type (Select one):
☐ New medical coverage ☐ Add dependent(s) to current coverage
☐ Change current coverage

Requested Effective Date
____________________ **(1st or 15th of the month). (Innovation Health will assign the effective date once your application has been processed.)**

Section C – Annual Open Enrollment Period

☐ Application submitted between **October 1, 2013** and **March 31, 2014**

Primary Applicant's Name

Section D – Special Enrollment Period

If you are applying outside of the Annual Open Enrollment Period and one of the events listed below applies to you, check the appropriate box. The Special Open Enrollment Period begins on the date of the event checked and continues for 60 days.

Date of Event	Event
____________	☐ Loss of employer coverage due to termination of employment, reduction in hours, or coverage no longer offered to my employment class.
____________	☐ Loss of employer or individual coverage because no longer eligible as a dependent.
____________	☐ Loss of employer or individual coverage because of divorce from policyholder, or policyholder eligible for Medicare.
____________	☐ Loss of Medicaid or CHIP coverage.
____________	☐ Coverage needed for new dependent through marriage, birth, adoption or placement for adoption.
____________	☐ Coverage needed following loss of eligibility for Exchange subsidies.
____________	☐ Other, please explain. ____________________________

If you have been enrolled in a plan that renews during 2014, you may apply during the 30-day period prior to your renewal date. If this applies, provide renewal date below:

☐ Date of renewal. ________________

Section E – Coverage Selection

Choose the plan that best meets your needs.

Catastrophic:	Bronze:	Silver:
☐ **Innovation Health Basic PD**	☐ **Innovation Health Advantage 6350 PD**	☐ **Innovation Health Classic 3500 PD**
	☐ **Innovation Health AdvantagePlus 5000 PD**	☐ **Innovation Health Classic 5000 PD**

Coverage Options:

☐ Morbid Obesity: Add coverage for treatment of morbid obesity (additional premium required)

Section F – Persons Requesting Coverage

List all family members you wish to be covered under this policy.

Dependent children are eligible up to age 26.

☐ Check here if more space is needed to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this application.

If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last 6 months, check Yes as Tobacco User below. Regular use means an average of four or more times per week.

Primary Applicant Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Spouse's Partner Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Domestic Partner Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 1 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 2 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No

continued

Primary Applicant's Name

Section F – Persons Requesting Coverage (Continued)

To be completed by the primary Applicant

Marital Status
☐ Married ☐ Domestic Partner ☐ Single

Are you a resident of the state in which you are applying?
☐ Yes ☐ No

If you are currently covered by accident and sickness insurance, is this plan intended to replace your current coverage?
☐ Yes ☐ No

How would you like Innovation Health to communicate with you regarding your application and coverage?
☐ E-mail ☐ Mail

Would you like to receive emails from us regarding your benefits, programs and general health information?
☐ Yes ☐ No

Would you like to turn off paper? ☐ Yes ☐ No

If you turn off paper, we will send you emails about your claims and other activity on your account. You can also view your statements and communications online.

Please note that there may be state regulations that prohibit us from communicating with you in your preferred method in some instances.

Are you a Native American Indian? ☐ Yes ☐ No

Are you a Citizen of the United States? ☐ Yes ☐ No

If "No," provide most recent date of arrival in the U.S.: ____________ INS ID Number: ____________________________

Are the other applicants being added to this application Citizens of United States? ☐ Yes ☐ No

If "No," provide Name, most recent date of arrival in the U.S. and INS ID Number.

Name	Most recent arrival date	INS ID Number

Do you read and write English? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

If "No," Primary Spoken Language: _______________________ Primary Written Language: _______________________

Did you complete this application? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

Statement of Accountability – Must be completed if the applicant answered "No" to read or write English or the applicant did not complete this application.

I _______________________________________, acting as (describe your relationship) _______________________________
have personally read this form to the applicant and completed the application because:

☐ Applicant does not have sufficient command of the English language to complete this application

☐ Applicant is legally incapacitated and unable to complete this application

I have read and explained in detail the contents of this application.

____

If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under **Sections G and J**.

Signature of Representative ***(Required)***			Today's Date ***(Required)***
Print Name			
Street Address			
City	State	ZIP Code	Telephone Number ( )

Primary Applicant's Name

Section G – Authorization to Use and Disclose Protected Health Information

Purpose of this Authorization Form
By signing this form, I authorize Innovation Health Insurance Company, or Innovation Health's representatives, to receive and use Protected Health Information (PHI) (e.g., hospital records, physician records, claims or benefit records or lab results) a) to verify tobacco use, b) to coordinate medical care and case management, and/or c) to determine future premium rates for Innovation Health's individual insurance line of business. For this purpose, I authorize Innovation Health to disclose my PHI to other persons or organizations performing services on Innovation Health's behalf.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, or authorized person that has any record or knowledge of my health to disclose such information to Innovation Health to the extent permitted by law.

I understand that my PHI may be used by, or disclosed to or by, organizations and persons who are subject to federal or state privacy laws.

Term of Authorization
I agree this Authorization shall be valid for eighteen (18) months from the signature date below.

Right to Revoke
I understand I may revoke this authorization at any time by giving advance written notice to Innovation Health. If this application was completed on a computer, I acknowledge that I have not actually signed this application but instead authorize Innovation Health to print "Electronic Signature" on this form.

I have read and considered the contents of this form.

I or my authorized representative has the right to receive a copy of this authorization form upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.

By signing this form, I understand that my signature will be used only for applying for health insurance with Innovation Health Insurance Company.

Signature	Date
Primary Applicant's or Parent/Guardian's Signature	Date
Spouse's Signature	Date
Domestic Partner's Signature	Date
Dependent's Signature (age 18 or older)	Date
Dependent's Signature (age 18 or older)	Date

Primary Applicant's Name

Section H – Payment Options (Select the method of payment for your initial application and following premium payments.)

Initial Payment

- ☐ Easy Pay – Electronic Check (complete the EFT information below)
- ☐ Credit Card (complete the credit card information below)

Recurring or Follow Up Payments

- ☐ Easy Pay (complete the EFT information below)
- ☐ Check or Money Order

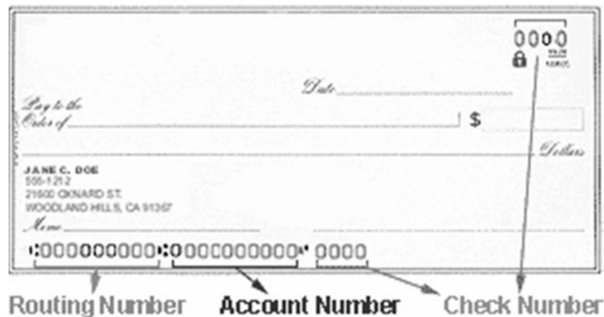
Easy Pay (Electronic Fund Transfer – EFT)

Checking Account Number: ______________________________

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: ______________________________

Name(s) on Checking Account: ______________________________



Terms of Agreement: My account(s) at the institution named has sufficient funds to pay all debits and charge credits. Innovation Health shall initiate electronic debit, charge, or credit entries to pay premiums/charges for authorized policies, and the entries are my transaction receipt. There is no payment to Innovation Health until Innovation Health receives full and final credit for the payment. I understand that corrections to the entries may involve an account adjustment, and that **my direct electronic payment of Innovation Health's premium will be debited/charged on or after the premium due date.** I understand that by electing the Easy Pay box above and with my application signature in **Section J**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account upon approval of your application *prior to the effective date*. Please be advised that tobacco use may result in an increase to the standard premium.

NOTE: Innovation Health reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Innovation Health/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Section J**) even if not applying.

Credit Card Payment Option

Credit Card Type ☐ Visa ☐ MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	Card Expiration Date

Credit card payment is for your initial premium payment only and will be charged upon approval of your application *prior to the effective date*. You must elect EFT or monthly billing (check or money order) for your next premium payment.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account. **Please be advised that tobacco use may result in an increase to the standard premium.**

Primary Applicant's Name

Section I – **Case Management (OPTIONAL** – This information will be used to help coordinate your care. It will not impact your premium rate or eligibility for coverage.)

Check all boxes that apply.

☐ AIDS	☐ Defibrillator /AICD	☐ Paralysis
☐ ALS (Lou Gehrig's Disease)	☐ Dialysis	☐ Paraplegic
☐ Auto Immune Disease	☐ End of Life/Hospice	☐ Pregnancy – high risk or multiple births
☐ Cerebral Palsy	☐ Hemodialysis	☐ Prosthesis present
☐ Chronic Pain	☐ Morbid Obesity (BMI > 42)	☐ Quadriplegic
☐ Clotting Disorder	☐ Multiple Sclerosis	☐ Surgery scheduled or pending
☐ Congestive Heart Failure	☐ Muscular Dystrophy	☐ Traumatic Brain Injury
☐ COPD using oxygen	☐ Myasthenia Gravis	☐ Other: ______________________________

Name of Applicant	**Condition(s)**

Section J – **Signature(s) Required** – **All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.**

By signing this form you agree to the following:

1. The answers in this application are true and complete to the best of my knowledge or belief.
2. The children listed on this application are eligible for coverage as my dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Innovation Health.
4. I have read this entire application, or it has been read to me.
5. The information I have provided in this application, except for Section I will be used by Innovation Health to determine whether to issue coverage and the premium amount for such coverage.
6. No coverage shall be in force until Innovation Health processes this application and Innovation Health has notified me of my effective date.
7. This application will become part of the contract between me and Innovation Health.
8. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
9. I authorize Innovation Health to electronically transmit the information contained in this application.
10. The undersigned Applicant(s) and agent (if applicable) certify that the Applicant(s) have read, or had read to him/them the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse's Signature	Date
Domestic Partner's Signature	Date
Dependent's Signature (age 18 or older)	Date
Dependent's Signature (age 18 or older)	Date
Agent's Signature	Date

Primary Applicant's Name

Section K – HIPAA Coverage

If I or my dependents do not qualify for the Innovation Health Insurance Plans, I would like to be considered for enrollment in coverage under HIPAA. HIPAA eligibility requirements are explained below. I understand there are no underwriting requirements and no preexisting exclusions apply. If I qualify, please offer the HIPAA coverage and provide details regarding rates.

If **Yes**, the following information must be provided.

Names of Applicant(s) requesting HIPAA coverage:

____

____

Question	Answer
1. Are you covered by or eligible for Medicaid, Medicare, or any other employer-sponsored health insurance benefits, or do you have other health coverage? If **Yes**, you are not eligible for coverage under HIPAA.	☐ Yes ☐ No
2. Have you had a minimum of 18 months* of continuous health care coverage most recently under any of the following: Health insurance coverage issued on a group or individual basis; Medicare; Medicaid; health care for the uniform services; a medical care program of the Indian Health Services or of a tribal organization; a state health benefits risk pool; The Federal Employees Health Benefit Plan (FEHBP); a public health plan (as defined in Federal Regulations); or any health benefit plan under section 5(e) of the Peace Corps Act, that ended within the last 63 days for a reason other than non-payment of premium or fraud? *Or a minimum of 12 months of continuous health care coverage if your most recent coverage was through an individual health insurance plan where the insurer offering the coverage exits the individual health insurance market and cancels your coverage. If **Yes**, please attach the Certificate of Coverage from your employer or carrier OR letter from the employer stating the following: Name of Applicant ____________________ Start Date (Mo/Day/Yr.) ____________________ End Date (Mo/Date/Yr.) __________ Name of insurance carrier(s) ____________________ Telephone No. __________ If **No**, you are not eligible for HIPAA coverage.	☐ Yes ☐ No
3. Were you eligible for COBRA or State Continuation coverage or conversion policy? If **Yes**, please provide the following information: Start Date (Mo/Day/Yr.) ____________________ End Date (Mo/Date/Yr.) __________ If **No**, please explain: ______________________________ **If COBRA or State Continuation coverage is not exhausted, you are not eligible for HIPAA coverage.**	☐ Yes ☐ No

Primary Applicant's Name

Section L – Insurance Producer or Agent (Required If Applicable)

Complete if Broker of Record is an Individual Producer (not an Agency)

Print Name of Producer	NPN of Agent
Signature of Producer (required if applicable)	Telephone Number ( )
E-mail Address	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Complete if Broker of Record is an Agency

Name of Agency N/A	TIN of Agency	
E-mail Address	Telephone Number ( )	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Print Name of Producer Representing Agency	NPN Number	
Signature of Agency Representative (required if applicable)		

General Agent

Print Name of General Agent N/A	TIN of General Agent
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Innovation Health Sales Representative

Last Name of Agent (Print Name) N/A	First Name of Agent (Print Name)	License Number

Section M – Contact Information

Please return this application to the agent or submit to the address listed below.

Innovation Health Insurance Plans
PO Box 14381
Lexington, KY 40512-4381

Fax #: 866-892-8396

Website for information: www.Innovation-Health.com