**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 underwriting 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 888-396-2341 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

**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 or 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

innovation HEALTH
Aetna | Inova PARTNERSHIP

# 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, Falls Church, Loudoun**

Corporate Address: Innovation Health Insurance Company
3190 Fairview Park, 9th Floor
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 terminated.**
- **Mailing Address for Application: Innovation Health Insurance Plans, PO Box 14381, Lexington, KY 40512-4381**

## Section A – Primary Applicant Information

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

## Section B – Coverage Information

Application Type (Select one):

**Annual Open Enrollment Period**

☐ New medical coverage ☐ Child-Only Application (Children up to age 21)
☐ Change current coverage ☐ Add dependent(s) to current coverage

**Your Effective Date will be assigned by Innovation Health, based on your signature date.**

## Section C – Coverage Selection

**Choose the plan that best meets your needs.**

*****Catastrophic:**
☐ **Innovation Health Catastrophic 100% PD**
***Must be under age 30 or qualify for an exemption. Proof of exemption will be required for each individual applying.

**Bronze:**
☐ **Innovation Health Bronze $25 Copay PD**
☐ **Innovation Health Bronze Deductible Only HSA PD**

**Silver:**
☐ **Innovation Health Silver $5 Copay 2750 PD**
☐ **Innovation Health Silver $10 Copay PD**

**Gold:**
☐ **Innovation Health Gold $5 Copay PD**

| 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 COBRA coverage. |
| _____ | ☐ 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 enrolled in Medicare. |
| _____ | ☐ Loss of Medicaid or CHIP coverage. |
| _____ | ☐ Coverage needed for new dependent through marriage. |
| _____ | ☐ Coverage needed for new dependent through birth, adoption or placement for adoption. |
| _____ | ☐ Coverage needed following loss of eligibility for Exchange subsidies. |
| _____ | ☐ A permanent move. |
| _____ | ☐ Other, please explain. _____ |

## Section E – Persons Requesting Coverage

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

Dependent children are eligible up to age 26.

**For a Child-Only application, start listing children at Child 1.**

☐ 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** 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 |
| **Child 3** 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 E – Persons Requesting Coverage (Continued)

**To be completed by the primary Applicant**

| | |
|---|---|
| Marital Status<br>☐ Married ☐ Domestic Partner ☐ Single | Are you a resident of the state in which you are applying?<br>☐ Yes ☐ No |
| If you are currently covered by accident and sickness insurance, is this plan intended to replace your current coverage?<br>☐ Yes ☐ No | |
| How would you like Innovation Health to communicate with you regarding your application and coverage?<br>☐ E-mail ☐ Mail | Would you like to receive emails from us regarding your benefits, programs and general health information?<br>☐ Yes ☐ No |
| Would you like to turn off paper? ☐ Yes ☐ No<br>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.<br>If you want to change this election, you can contact Member Services at the number on the back of your ID Card. | |
| Are any applicants enrolled in or entitled to Medicare benefits? ☐ Yes ☐ No<br>If Yes, provide name(s) of these applicants: _____ | |
| Are all applicants listed on this application Citizens of the United States? ☐ Yes ☐ No<br>If No, provide Name, most recent date of arrival in the U.S.<br>Name _____ Most recent arrival date _____<br>_____ _____<br>_____ _____ | |
| Do you read and write English? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)<br>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.**<br>I _____, acting as (describe your relationship) _____<br>have personally read this form to the applicant and completed the application because:<br>☐ Applicant does not have sufficient command of the English language to complete this application<br>☐ Applicant is legally incapacitated and unable to complete this application<br>I have read and explained in detail the contents of this application.<br>_____<br>If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under **Sections F and H**. | |
| Signature of Representative ***(Required)*** | Today's Date ***(Required)*** |
| Print Name | |
| Street Address | |

| City | State | ZIP Code | Telephone Number<br>( ) |
|---|---|---|---|
| | | | |

| Primary Applicant's Name |
|---|
| |

## Section F – Authorization to Use and Disclose Protected Health Information

**Please read the following carefully before completing your authorization. You may refuse to sign this authorization.**

**Purposes of this Authorization**

By signing this authorization, I authorize Innovation Health Insurance Company (Innovation Health) or Innovation Health's representatives to request, receive and use prescribed medication history or other pharmaceutical information, hospital records, physician records, claims or benefit records or lab results (all of which are "Protected Health Information" or "PHI") as necessary a) to verify tobacco use and b) to coordinate medical care and case management. I authorize Innovation Health to disclose my PHI for the purposes stated above 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, lab, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or 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 Innovation Health may pay a fee to a third party to collect my health information. The health information released to Innovation Health may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS),

Innovation Health may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by Innovation Health will not be re-disclosed without your authorization unless permitted by law, as described in Innovation Health's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal privacy laws.

I or a person authorized to act on my behalf may obtain a copy of this authorization upon request.

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

I understand that I may revoke this authorization at any time by giving advance written notice to Innovation Health. My revocation will not have any effect on actions Innovation Health has already taken before receiving my notice.

| | |
|---|---|
| **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 G – 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)

☐ Monthly Billing Statement

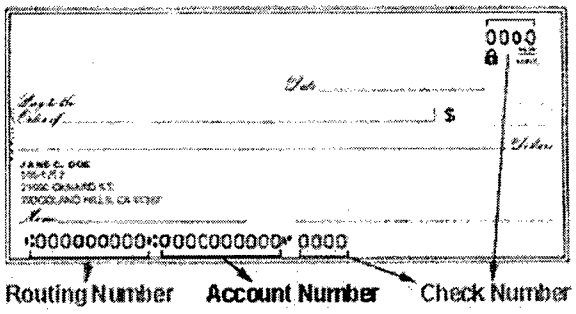
**Easy Pay (Electronic Fund Transfer – EFT)**

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 H**, 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 H** 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 H – 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 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 Innovation Health and me.
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.

**If while covered under this plan, you are also covered under an Innovation Health group plan, you will be entitled only to the benefits of the group plan. If you have insurance coverage with another insurer, we will only pay benefits for covered benefits that exceed the benefits payable under the other coverage. In no event will Innovation Health's payment, if added to the payment under the other coverage, be larger than the amount payable for the health services received by the covered person.**

| | |
|---|---|
| **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 I – Insurance Producer or Agent (Required If Applicable)

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

| | |
|---|---|
| Print Name of Producer<br>**Jonathan Katz** | NPN of Agent<br>**1585616** |
| Signature of Producer (required if applicable) | Telephone Number<br>( **800** ) **867-0800** |
| E-mail Address<br>**jkatz@vamedicalplans.com** | Fax Number<br>( **888** ) **514-4258** |
| Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)<br>**1404 Northpoint Glen Court / Herndon / VA / 20170** | |

**Complete if Broker of Record is an Agency**

| | | |
|---|---|---|
| Name of Agency | TIN of Agency | |
| E-mail Address | Telephone Number<br>( ) | Fax Number<br>( ) |
| 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 | 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) | First Name of Agent (Print Name) | License Number |
|---|---|---|
| | | |

## Section J – 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**