VIRGINIA MEDICAL PLANS
FAMILY & BUSINESS HEALTH INSURANCE

Anthem.
AUTHORIZED INDEPENDENT AGENT

Application Instructions for Anthem Blue Cross and Blue Shield of Virginia

1. Please print the enclosed application and write legibly with blue or black ink. Please be sure to complete all sections and quesitons.

2. Complete the fax cover letter and application and fax, email, 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. You can also scan and email the completed application to jkatz@vamedicalplans.com.

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 Extras Packages Senior Enrollment Application for Virginia

Anthem BlueCross BlueShield

Send your completed application to:
Virginia Medical Plans
1404 Northpoint Glen Ct
Herndon, VA 20170
Fax: 1-888-514-4258 | Email: jkatz@vamedicalplans.com

Please print – complete in blue or black ink only.

Important: To be eligible to apply for this coverage, you must be 65 years of age or older.

Section A – Applicant Information

******This information is used for internal purposes only and will not be disclosed.*

Last Name	First Name	MI	Social Security Number*

Home Address **(Must be complete. P.O. Box not acceptable)**	City	State	ZIP Code

Mailing Address **(if different from above or for P.O. Box)**	City	State	ZIP Code

County	Gender	Date of Birth	Age	Daytime Phone Number	Evening Phone Number
	☐ M ☐ F	/ /		( )	( )

Email Address (not shared with any third party)	

Do you currently have dental insurance that this new coverage will replace? ☐ Y ☐ N

If you currently have medical or dental coverage through Anthem Blue Cross and Blue Shield, please provide:	If you are a current Anthem Blue Cross and Blue Shield member, what insurance do you have with us?
Member Identification Number: _____ Effective Date: _____ Termination Date: _____	☐ Individual Health ☐ Group Health ☐ Group Vision ☐ Individual Dental ☐ Group Dental

Section B – Coverage Information

Effective date requested: If your application is approved, your coverage can start on any day of the month after the date we receive your application.

Please choose the date you would like your coverage to start: _____/_____/_____ (MM/DD/YY).

☐ Standard Package ☐ Premium Package ☐ Premium Plus Package ☐ Premium Plus Dental ***(only)***

Section C – Billing Information

Frequency (select one)	Initial Premium ☐ Automatic Bank Draft (see below) ☐ Premium Check Enclosed (make check payable to ***Anthem Blue Cross and Blue Shield***)
☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually	**Total amount enclosed** $ _____

If you submit a personal check for premium payments, you automatically authorize us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

Method (select one)

☐ **HOME –** Bills will be sent to your home address unless you list an alternate address here:

Name _____

Street Address (and P.O. Box, if applicable) _____

City _____ State _____ ZIP Code _____

☐ **AUTOMATIC BANK DRAFT** – Premium is deducted on the same day of the month as your effective date; ***you must attach a blank, voided check.***

If selecting Automatic Bank Draft: I authorize Anthem Blue Cross and Blue Shield (Anthem) to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. This authorization is in effect until I notify in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals at their discretion.

Account holder's name (please print)
X _____

Account holder's signature (if other than the applicant)
X _____

Section D – Agreement Signature Required

The undersigned applicant and agent certify that the applicant has read, or has read to him, 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. **The applicant understands that there are waiting periods in the Premium and Premium Plus packages, and Premium Plus Dental Only.**

Signature of Applicant or Legal Guardian or Power of Attorney	Date

Section E – Agent Certification

Agent Information and Declaration: To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation.

Agent Signature	Date

Agent Name (please print)	Agent Street Address/Suite Number/Personal Mailbox (PMB) Number
Jonathan Katz	1404 Northpoint Glen Court

Writing Agent Tax ID Number	City/State/ZIP Code	County	Area Code
GDGKGSSMNZ	Herndon / VA / 20170	Fairfax	703

Agent Phone Number	Agent Fax Number	Agent Email Address
703-707-8270	888-514-4258	jkatz@vamedicalplans.com

Payable Agent/Agency Name (if applicable) (please print)	Payable Agent/Agency Tax ID Number (if applicable)
Jonathan Katz / Employee Benefits Corporation of America	JDKHMSLKQY