Anthem
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 (Anthem).

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.

Call Virginia Medical Plans / Katz Insurance Group at: 703-707-8270

About this form

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

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   Your coverage will start based on when we receive your complete application; however, the earliest your coverage can start is January 1st..
2. **Due to a qualifying event**
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about when coverage starts.
3. **For new dental and vision**
   - For new dental and vision coverage, you can apply any time during the year.
   - If you apply with medical, your effective dates will match.
   - If you apply without medical, your coverage will start based on when we receive your complete application. If we get it between the 1st and last day of the month, coverage is effective the 1st day of the following month.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. Please submit all pages.
3. You can also apply online at anthem.com.
4. 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 or money order until you've been enrolled.
2. **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 may give it to our HSA banking partner.

Please indicate the reason you are submitting this application for medical:
☐ Open Enrollment
☐ Special Enrollment Period – must also complete Appendix A

Step 1: Who is applying?

☐ New coverage
☐ Change coverage
☐ Add dependent to existing coverage
Subscriber ID no. _____

Primary Applicant

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security No.** - -

Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of VA** ☐ Yes ☐ No	**County** (for home address)	**Tobacco use**[1] ☐ Yes ☐ No

Home address (not a P.O. Box)	**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 _____
For myself and any dependents, I'm adding my email address above because I agree to get my policy, certificate, or evidence of coverage electronically. I know I can change my mind at any time and request a free copy of specific materials by mail. I also understand that by adding my email address, information about my dependents may also be sent by email or electronically. To do either, I (or my enrolled dependent) will update our communication preferences by going to anthem.com or calling Member Services.

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

Coverage(s) selected ☐ Medical* ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

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	**Tobacco use**[1] ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

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 or Domestic Partner.

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	**Tobacco use**[1] ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

1 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).

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	**Tobacco use**[1] ☐ Yes ☐ No
Coverage(s) selected ☐ Dental* ☐ Vision*				

*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

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	**Tobacco use**[1] ☐ Yes ☐ No
Coverage(s) selected ☐ Dental* ☐ Vision*				

*Primary applicant must be included for Spouse or Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

1 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 The answers to these questions are needed to determine your eligibility.

Are any applicants enrolled in 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?**	

Step 2: What coverage would you like?

Medical Plans

Choose only one medical plan.

Our plans are available in the counties of Accomack, Albemarle, Alleghany, Amherst, Appomattox, Augusta, Bath, Bedford, Bland, Botetourt, Brunswick, Buchanan, Buckingham, Campbell, Caroline, Carroll, Charlotte, Craig, Culpeper, Cumberland, Dickenson, Essex, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Henry, Highland, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lee, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Patrick, Pittsylvania, Powhatan, Prince Edward, Pulaski, Rappahannock, Richmond, Roanoke, Rockbridge, Rockingham, Russell, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Surry, Tazewell, Washington, Westmoreland, Wise, Wythe, York, and the cities of Bedford, Bristol, Buena Vista, Charlottesville, Chesapeake, Covington, Danville, Emporia, Franklin, Fredericksburg, Galax, Hampton, Harrisonburg, Lexington, Lynchburg, Martinsville, Newport News, Norfolk, Norton, Poquoson, Portsmouth, Radford, Roanoke, Salem, Staunton, Suffolk, Virginia Beach, Waynesboro, Williamsburg, Winchester.

Our plans are not available in 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
☐ 4900 for HSA (3749) ☐ 5250 (374C) ☐ 5700 Online Plus (375N) ☐ 5900 (374F) ☐ 6500 (374J)	☐ 1800 (375A) ☐ 6100 (375G)	☐1350 (374P)
Anthem HealthKeepers Catastrophic	Only available to applicants under age 30, unless otherwise qualified.	
☐ 7900 (374M)		

Health Savings Account (HSA) Enrollment	If you choose an HSA compatible plan, you have the option to set up a health savings account.
☐ Yes, I'd like to establish an HSA with HealthKeepers, Inc.'s banking partner. (Please make sure you entered Social Security numbers in Step 1)	
Current (existing) medical coverage	
☐ 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 Healthkeepers 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 if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan options

☐ Anthem Dental Family Value (2J5G)
☐ Dental Prime A (1RCJ)
☐ Anthem Dental Family (1FVK)
☐ Dental Prime B (1RCK)
☐ Anthem Dental Family Enhanced (1FVL)
☐ Dental Prime C (1RCL)

Prior & other dental coverage

Name of person covered (Last, First, M.I.)	**Coverage (check all that apply)**	**Insurer name**	**Insurer phone no.**	**Policy ID no.**	**Dates (if applicable) (mm/dd/yyyy)**
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/_____ **End:** ____/____/_____

Will you be replacing this dental coverage if approved for Anthem's coverage? ☐ Yes ☐ No	If **Yes,** what is the termination date? (mm/dd/yyyy) / /

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

Vision Plan

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 if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan options

☐ Blue View Vision Individual (1RYB)

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 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, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem and Healthkeepers, Inc know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Anthem 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 and Healthkeepers, Inc automatic debit process and will only occur each time I send a check to Anthem 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 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 and I'm responsible for all of the premium payments and making sure that all premiums are paid.
- 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 sign this application for and on behalf of any eligible dependents and myself if covered by Anthem and Healthkeepers, Inc. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem and Healthkeepers, Inc absent the acknowledgement and consent of Anthem and Healthkeepers, Inc.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of health care services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the Evidence of Coverage, commercial entity with a direct or indirect financial interest in the benefits of the Evidence of Coverage or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.
The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.
Dental plans may contain waiting periods for certain types of services as disclosed in marketing materials and your policy. A waiting period is the length of time you must be covered under your dental policy and pay premiums before we will pay for covered services. You are eligible for payment of covered services once your waiting period has been met.

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
	Agent/Broker signature	Date

Payment Methods for Individual Applications

Anthem And Its Affiliate HealthKeepers, Inc.

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) and/or HealthKeepers, Inc. (HealthKeepers) will accept monthly payments on behalf of applicants/members **if the payment is made by the following persons or entities:** The Ryan White HIV/AIDS Program; other federal and state government programs that provide monthly payments and cost-sharing support for specific individuals; Indian tribes, tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem and/or HealthKeepers does not accept monthly payments from third parties that are not listed above. Examples of third parties from whom Anthem and/or HealthKeepers will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, doctors, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan. Note: As allowed by law, Anthem and/or HealthKeepers reserves the right to decline monthly payments from third parties.

I authorize Anthem and/or HealthKeepers to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem and/or HealthKeepers of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem and/or HealthKeepers may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem and/or HealthKeepers may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

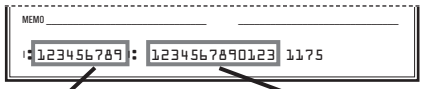
All of your monthly payments will be taken out of the **bank account** you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ___ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



9-digit bank routing number	Bank account number

I authorize Anthem and/or HealthKeepers to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem and/or HealthKeepers' rights with each debit are the same as if the debit was a check that I signed.** I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem and/or HealthKeepers to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem and/or HealthKeepers know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem and/or HealthKeepers to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Authorized signature (as it appears on bank's records)	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
X		

☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card ___ (1st to 6th of each month).

I authorize Anthem and/or HealthKeepers to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem and/or HealthKeepers to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem and/or HealthKeepers, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem and/or HealthKeepers credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem and/or HealthKeepers will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Anthem and/or HealthKeepers accepts ☐ **Visa or** ☐ **Mastercard (Note to applicant: Please check one.)**

Card number	Expiration date ___ (MM/YY)

Billing address for this credit/debit card	City	Zip code

Authorized signature (as it appears on card)	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)
X		

See page two for *Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.*

Payment Methods for Individual Applications

Anthem®
And Its Affiliate HealthKeepers, Inc.

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☒ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. **Electronic check:** Instead of sending us a paper check, you can use an electronic check that allows Anthem and/or HealthKeepers to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment
			$

B. **Credit/Debit card:** I allow Anthem and/or HealthKeepers to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem and/or HealthKeepers.

Anthem and/or HealthKeepers accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	Zip code

I authorize Anthem and/or HealthKeepers to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem and/or HealthKeepers will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem and/or HealthKeepers receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

Information for Applicants Requesting a Special Enrollment Period

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

When applying to enroll for coverage during a Special Enrollment Period (SEP), 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
Lost or will lose Minimum Essential Coverage: 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) 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, 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, 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, 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, if available) confirming loss of coverage (date and individuals), and • Divorce decree, legal separation agreement, or notarized/legal termination of domestic partnership or civil union **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

Qualifying event	Description and examples of supporting documentation
Lost or will lose Minimum Essential Coverage: 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 (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 country or a United States territory (See below).* • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming coverage (date and individuals) within the past 60 days. If the minimum essential coverage has not yet been terminated, supporting documentation must show the applicant had minimum essential coverage for one or more days in the 60 days prior to the permanent move. **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, court order or a child in foster care is placed with you If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	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 If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	**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 Anthem members, a mother's delivery claim may be considered as supporting documentation*. **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 If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	Certificate of marriage or domestic partnership. ***NOTE: At least one spouse or domestic partner must either demonstrate that they had Minimum Essential Coverage or that they lived in a foreign country or US territory for one or more days in the 60 days prior to the date of the marriage or 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, VISA, or airplane ticket, **and** ∘ Documentation of the new address which may be validated by any of the following: — Signed residential lease, rental agreement/contract, mortgage — A deed showing applicant ownership of property in the new service area — 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.

Qualifying event	Description and examples of supporting documentation
	• **And** one additional supporting document of new address which may be validated by one of the following in the applicant's name: — Recent utility bill (electric, water, phone, internet, cable) — 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 or letter/employment contract from employer — Voter registration card showing name and address — Moving company contract or receipt showing address
Release from incarceration	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge
Death of a family member enrolled under current coverage	• Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming coverage (date and individuals), **and** • Copy of death certificate or obituary
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.
Current policy does not renew on a calendar year basis (renews on a date other than January 1)	Information from previous carrier (recent billing statement, ID card, renewal letter) confirming coverage (date and individuals) and renewal date of coverage.
Delay in Medicaid/FAMIS eligibility determination	Letter from agency
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events	A letter from the applicant and 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.