



Primary Applicant: \_\_\_\_\_

- New Coverage Plan Year: \_\_\_\_\_
- Add Dependent VHP ID No. \_\_\_\_\_
- Change Coverage VHP ID No. \_\_\_\_\_

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## LANGUAGE SUPPORT

### English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1.888.421.8444 (California Relay Service (CRS) 711).

### Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.421.8444 (California Relay Service (CRS) 711).

### Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.421.8444 (California Relay Service (CRS) 711).

### Tagalog (Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.421.8444 (California Relay Service (CRS) 711).

### 한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.421.8444 (California Relay Service (CRS) 711)번으로 전화해 주십시오.

### 繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.421.8444 (California Relay Service (CRS) 711)。

### Հայերեն (Armenian)

Ուշադրութեամբ խնամել էք հայերեն, սպասե՛ք անվճար կարող են տրամադրվել լեզվակազմակերպչական ծախսերը: Ձանգահարեք 1.888.421.8444 (California Relay Service (CRS) 711):

### Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.421.8444 (California Relay Service (CRS) 711).

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## LANGUAGE SUPPORT

### فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با  
1.888.421.8444 (California Relay Service (CRS) 711) تماس بگیرید.

### 日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。  
1.888.421.8444 (California Relay Service (CRS) 711) まで、お電話にてご連絡ください。

### Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.888.421.8444 (California Relay Service (CRS) 711).

### ਪੰਜਾਬੀ (Punjabi)

ਪਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।  
1.888.421.8444 (California Relay Service (CRS) 711) 'ਤੇ ਕਾਲ ਕਰੋ।

### العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.421.8444 (California Relay Service (CRS) 711).

### (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।  
1.888.421.8444 (California Relay Service (CRS) 711) पर कॉल करें।

### ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร  
1.888.421.8444 (California Relay Service (CRS) 711).

### ខ្មែរ (Cambodian)

ប្រយ័ត្ន: បរិស្ថានជាអ្នកនិយាយភាសាខ្មែរ, បសវ័ជន្តួយខ្លួនកភាសា បោយមិនគិតគូរ  
គឺអាចមានសំរាប់បរិស្ថាន។ ចូរ ទូរស័ព្ទ 1.888.421.8444 (California Relay Service (CRS) 711).

### ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ, ແມ່ນມີອັ້ມໃຫ້ທ່ານ. ໂທ 1.888.421.8444 (California Relay Service (CRS) 711).

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## GENERAL INFORMATION

<p><b>Who can use this application?</b></p>	<ul style="list-style-type: none"> <li>All applicants on this application <b>MUST</b> live in Santa Clara County.</li> <li>If you qualify for financial assistance (federal help payment copayments, coinsurance, deductibles, or premiums), apply for coverage at <a href="http://www.coveredca.com">www.coveredca.com</a> through Covered California.</li> </ul>
<p><b>How to submit this application?</b></p>	<ol style="list-style-type: none"> <li>Complete the application and print all pages</li> <li>Submit completed application and required documents by:           <p>Mail: Valley Health Plan Attn: Sales &amp; Broker Relations 2480 North 1<sup>st</sup> St, Suite 160 San Jose, CA 95131</p> <p>Email: <a href="mailto:BrokerRelations@vhp.sccgov.org">BrokerRelations@vhp.sccgov.org</a></p> <p>Secure Fax: <b>(408)954-1027</b></p> </li> </ol>
<p><b>How to make a payment?</b></p>	<p>You may send a check or money order to Valley Health Plan's payment center:</p> <p>Please make check payable to <b>VALLEY HEALTH PLAN</b></p> <p>MAIL TO:</p> <p>STANDARD <b>San Francisco Lockbox</b> County of Santa Clara - VHP PO Box 398435 San Francisco, CA 94139-8435</p> <p>OVERNIGHT MAIL <b>Fremont Lockbox</b> Wells Fargo Lockbox Services Dept #38435 3440 Walnut Ave, Bldg A, Window H Fremont, CA 94538</p> <p>You may pay by <b>credit card, debit card or eCheck</b>, use our <b>On-line payment tool</b>: <a href="http://www.ValleyHealthPlan.org/paybill">www.ValleyHealthPlan.org/paybill</a></p> <p>If you have any questions, please contact VHP Member Services at <b>1.888.421.8444</b> (toll-free) between 8am to 5pm, Monday through Friday, not including holidays.</p>
<p><b>When will coverage become effective?</b></p>	<p>During <b>Open Enrollment</b>, coverage effective date will be on <b>January 1<sup>st</sup></b>, after we've received your first premium payment. <b>During Special Enrollment Period</b>, coverage effective date corresponds to the qualifying life event. Please refer to the Special Enrollment section for more details.</p>
<p><b>Need help completing this application?</b></p>	<ul style="list-style-type: none"> <li>For help completing this application, please call VHP Sales &amp; Broker Relations at <b>408.885.3560</b>.</li> <li>If you have an agent or broker, please call him or her for help.</li> </ul>

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

Select if completing application during **Special Enrollment Period**

## SPECIAL ENROLLMENT PERIOD

### QUALIFYING EVENT DATE

For Loss of Coverage, enter the last date of coverage. For all other events, please enter the date based on the qualifying event. You must apply for coverage within **60 days** before or after your qualifying event.

Applications submitted during **Special Enrollment Period**, require the applicant to be eligible to enroll and provide supporting documentation of a qualifying event. 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.

Unless otherwise noted below, coverage date is based on when VHP receives your application. If VHP receives it:

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

### QUALIFYING EVENT (select one)

### DOCUMENTATION

### COVERAGE EFFECTIVE DATE

QUALIFYING EVENT (select one)	DOCUMENTATION	COVERAGE EFFECTIVE DATE	
<b>Change in family size</b>	<input type="checkbox"/> <b>Birth, Adoption or Foster Care</b> Had a baby, adoption of a child or placement of a child with you for foster care or adoption.	Birth certificate or medical records from hospital or pediatrician, adoption papers, foster care papers	<input type="checkbox"/> 1st day of the month after the event date <input type="checkbox"/> 1st day of the month after a completed application is received <input type="checkbox"/> Based on when VHP receives your completed application
	<input type="checkbox"/> <b>Marriage, Divorce or Legal Separation</b>	Filed court papers, notarized/legal termination of domestic partnership	1st day of the month after we receive your completed application
	<input type="checkbox"/> <b>Death of an Enrollee</b> Death of a family member enrolled under current coverage.	Death certificate or obituary	<input type="checkbox"/> 1st day of the month after we receive your completed application <input type="checkbox"/> Based on when VHP receives your completed application.
	<input type="checkbox"/> <b>Court Order Mandate</b> Required by a court order to provide an eligible child(ren) coverage.	Court order	<input type="checkbox"/> 1st day of the month after we receive your completed application <input type="checkbox"/> Based on when VHP receives your completed application.
<b>Change or Loss of health coverage</b>	<input type="checkbox"/> <b>Employer-sponsored</b> Involuntary loss of coverage or eligibility as a result of termination, change in relationship status, dependent status, number of work hours, etc.	Letter from employer	1st day of the month after VHP receives your completed application
	<input type="checkbox"/> <b>Other Programs (i.e. Medi-Cal, COBRA, Covered CA, IHSS, Healthy Families, etc.)</b> Involuntary loss of coverage or eligibility as a result of income change, employment status, relationship status, release from jail/incarceration, release from active military duty, etc.	Letter from, local, state or federal agency,  Letter that provides notice of termination of COBRA or state continuation benefits.	1st day of the month after VHP receives your completed application

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SPECIAL ENROLLMENT (continued)

QUALIFYING EVENT (select one)		DOCUMENTATION	COVERAGE EFFECTIVE DATE	
<b>Change in residence</b>	<input type="checkbox"/>	<b>Moved to Santa Clara County</b> Permanent move from another country, state or county.	<b>Proof of residency:</b> <ul style="list-style-type: none"> <li>• Recent utility bill</li> <li>• Signed lease, rental, mortgage or assisted living facility agreement</li> <li>• A deed of property ownership</li> <li>• New driver's license or state ID</li> <li>• Property tax receipt</li> <li>• Insurance documents</li> <li>• Mail from DMV</li> <li>• Official school documents</li> <li>• Mail from a government agency</li> <li>• Mail from a financial institution</li> <li>• Pay stub with address</li> <li>• Voter registration card</li> <li>• If homeless or in transitional housing, a letter from another resident of the same state, certifying they know where you live.</li> <li>• If living in someone else's home, a statement from that person certifying you're living with them.</li> </ul>	Based on when we receive your completed application  <input type="checkbox"/> Between the 1 <sup>st</sup> and 15 <sup>th</sup> day of the month, coverage is effective the 1 <sup>st</sup> day of the following month.  <input type="checkbox"/> Between the 16 <sup>th</sup> and the last day of the month, coverage is effective the 1 <sup>st</sup> day of the second following month.

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 1 – SELECT A PLAN

Choose only one plan option for your whole family. If a family member wants a different plan option they must complete a separate application.

Catastrophic (Up to age 30)	Bronze	Silver	Gold	Platinum
<input type="checkbox"/> Minimum Coverage Plan	<input type="checkbox"/> Bronze 60 HMO	<input type="checkbox"/> Silver 70 HMO	<input type="checkbox"/> Gold 80 HMO	<input type="checkbox"/> Platinum 90 HMO

- All plan options for the Individual & Family Plan include pediatric dental and vision benefits for those up to age 19.**
- The **Minimum Coverage Plan** is a high-deductible plan option for applicants up to age 30. Certain persons age 30 and older may apply for this plan if they submit a certificate of exemption from Covered California for each person that indicates lack of affordable coverage or hardship with their completed application.
- For services subject to a deductible, you will have to pay health care expenses out-of-pocket until you meet your deductible. For information describing the benefits and limitations, cost-sharing amounts, premiums, pediatric dental and vision plans, please review the details in your enrollment materials. To request a copy of the Combined Evidence of Coverage (EOC) and Disclosure Form for a particular plan, please call VHP Member Services at **1.888.421.8444** or contact your agent or broker.

## SECTION 2 – COMPLETE APPLICANT(S) INFORMATION

In the individual plan, the primary applicant is the person who will be covered by the health plan. In the family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is for minors (under 18), the oldest applicant is the primary applicant.

### PRIMARY APPLICANT

Last Name	First Name	Middle Name
Home Address (No PO Boxes)		Apt#
City	State	ZIP
Phone	Secondary Phone	Email
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial

### SELECT A PRIMARY PHYSICIAN (PCP)

VHP Primary Care Physician (Last, First) – Refer to Provider List	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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### SPOUSE OR DOMESTIC PARTNER

Last Name	First Name	Middle Name
Relationship to Primary Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner		Date of Birth
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial

### SELECT A PRIMARY PHYSICIAN (PCP)

VHP Primary Care Physician (Last, First) – Refer to Provider List	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 2 – COMPLETE APPLICANT(S) INFORMATION (continued)

Please complete the following information for each dependent covered under your plan. If you need space for additional applicants, attach another application and complete just the information for those applicants.

Children over the age of twenty-six (26) may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

DEPENDENT 1		
Last Name	First Name	Middle Name
Relationship to Primary applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional)  <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional)  <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial
SELECT A PRIMARY PHYSICIAN (PCP)		
VHP Primary Care Physician (Last, First) – Refer to Provider List		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT 2		
Last Name	First Name	Middle Name
Relationship to Primary applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional)  <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional)  <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial
SELECT A PRIMARY PHYSICIAN (PCP)		
VHP Primary Care Physician (Last, First) – Refer to Provider List		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT 3		
Last Name	First Name	Middle Name
Relationship to Primary applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional)  <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional)  <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial
SELECT A PRIMARY PHYSICIAN (PCP)		
VHP Primary Care Physician (Last, First) – Refer to Provider List		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 2 – COMPLETE APPLICANT(S) INFORMATION (continued)

### DEPENDENT 4

Last Name	First Name	Middle Name
Relationship to Primary applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial
<b>SELECT A PRIMARY PHYSICIAN (PCP)</b>		
VHP Primary Care Physician (Last, First) – Refer to Provider List		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

### DEPENDENT 5

Last Name	First Name	Middle Name
Relationship to Primary applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial
<b>SELECT A PRIMARY PHYSICIAN (PCP)</b>		
VHP Primary Care Physician (Last, First) – Refer to Provider List		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

### DEPENDENT 6

Last Name	First Name	Middle Name
Relationship to Primary applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)
Ethnicity (optional) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Race (optional) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Multi-Racial
<b>SELECT A PRIMARY PHYSICIAN (PCP)</b>		
VHP Primary Care Physician (Last, First) – Refer to Provider List		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No



# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 3 – PARENT OR LEGAL GUARDIAN INFORMATION

Complete if the primary applicant is a dependent under the age of 18.

Is the Primary Applicant under the age of 18?  Yes  No

PARENT OR LEGAL GUARDIAN			
Last Name	First Name	Middle	
Same address as Primary Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No      If No, fill in your address below:			
Street Address (No PO Boxes)			Apt#
City	State	Zip Code	County
Phone		Other Phone	
Email Address (if any)		Parent/Legal Guardian Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)	

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 4— APPLICATION AGREEMENT

**All applicants and dependents age 18 or older must read and sign below.** If the primary applicant is younger than 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copayments, coinsurance, and deductibles for all the applicants listed on this form.

### APPLICANT AGREEMENT

All faxed and mailed correspondence must be signed and dated by the applicant or someone legally authorized to act on his or her behalf. The applicant or his or her authorized representative may request a copy of the completed application. For more information, please call VHP Sales & Broker Relations at **408.885.3560**.

Important: Required signatures—all applicants age 18 or over must sign and date below on the appropriate signature line. A parent or legal guardian must sign for family members under the age of 18. If signatures are missing, we cannot process the application.

By signing below you are attesting to the following:

- I have provided true and correct answers to all the questions on this form to the best of my knowledge, and
- I know that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law, and
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, disability, age, sex, sexual orientation, gender identity, or religion. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file) or [www.healthhelp.ca.gov](http://www.healthhelp.ca.gov) or [www.dfeh.ca.gov](http://www.dfeh.ca.gov)
- I know all benefits received must be provided or authorized by VHP, and
- I know that VHP is authorized to obtain and release medical information in compliance with the insurance information and Privacy Protection Act, Section 791 et. Seq. of the California Insurance Code, and
- I, and the persons listed, will abide by the provisions of the Individual & Family Plan; and
- I, and the persons listed, are not eligible nor are enrolled in any other health insurance plan (including Medicare); and
- I will inform VHP upon such eligibility.

### ACKNOWLEDGEMENTS AND SIGNATURE

By submitting an electronic application; entering your name in the signature section below has the same legal significance as an original signature.

Primary Applicant or Parent or Legal Guardian for applicants under age 18	Date
Spouse/Domestic Partner	Date
Dependent (age 18 and older)	Date
Dependent (age 18 and older)	Date
Dependent (age 18 and older)	Date
Dependent (age 18 and older)	Date

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 5— AUTHORIZED REPRESENTATIVE INFORMATION

Complete this section if you would like another person to act as your authorized representative.

### YOU MAY CHOOSE AN AUTHORIZED REPRESENTATIVE

You may choose to give a trusted friend or partner permission to talk about this application with VHP. This person is called an authorized representative and you are permitting them to discuss this application, see your information, or act for you on matters related to this application.

Last Name		First Name		Middle	
Same address as Primary Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No      If No, fill in your address below:					
Street Address (No PO Boxes)				Apt#	
City		State	Zip Code	County	
Phone			Other Phone		
Your Preferred Written Language (if not English)			Your Preferred Spoken Language (if not English)		

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on matters related to this application.

By submitting an electronic application; entering your name in the signature section below has the same legal significance as an original signature

X \_\_\_\_\_

Primary applicant or parent or legal guardian for applicants under age 18

Date (MM/DD/YYYY)

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 6 – AGENT/BROKER/VHP REPRESENTATIVE

### FOR APPLICANTS USING AN AGENT/BROKER/VHP REPRESENTATIVE

This section should be completed by your agent, broker, or VHP representative after completion of this application.

A VHP representative is an employee who works at Valley Health Plan.

An agent or broker may receive monetary and/or non-monetary payments from HP in connection with the purchase of this coverage.

**Note: Premiums are the same whether or not you use an agent, broker, or VHP representative.**

### AGENT, BROKER AND VHP REPRESENTATIVE INFORMATION

Notice to agent, broker, and VHP representative. If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subjected to a civil penalty of up to ten thousand dollars (\$10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

### ACKNOWLEDGMENTS AND SIGNATURE

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

YES  NO

Agent/Broker/VHP Representative Signature

Date

Agent/Broker/VHP Representative Name (Last, First, Middle)

Agent or Broker CA DOI Identification Number

Street Address (No PO Boxes)

City

State

Zip Code

Phone

Fax

Email Address