Valley Health Plan®

LIFE CHANGING EVENT APPLICATION

If you have a life changing event, you and your family may still be able to get health coverage. To apply, please:

1. Complete the application and print all pages.
2. Mail or deliver the completed application and required documents to:

Valley Health Plan
2480 North First Street, Suite 200
San Jose, CA 95131

Or send a secure fax to: 408.885.4425

If you have any questions, please contact Member Services at **1.888.421.8444 (toll-free)**.

Enrollee Name(s): _____

Please check the box that best applies:

LIFE CHANGING EVENT	☑	DETAILS	REQUIRED DOCUMENTS
Change in family size	☐	Birth or adoption	– Birth certificate – Adoption papers
	☐	Court-ordered mandate	– Court order
	☐	Marriage, divorce, or legal separation	– Filed court papers
	☐	Death of subscriber	– Death Certificate
	☐	Dependent status change	– Birth Certificate – Filed court papers, if applicable
Change in work status	☐	Loss of employer-sponsored health coverage	– Letter from employer (Including reason for loss of coverage such as lay-off, retirement, termination, or decrease in work hours)
Change in residence	☐	Moved to Santa Clara County	– Proof of residency Dated within past 63 days (i.e. utility bill)

Valley Health Plan®

INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

Spanish
IMPORTANTE: ¿Puede leer esta aplicación? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta aplicación escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al **1.888.421.8444 (toll-free)**.

Vietnamese
QUAN TRỌNG: Quý vị có đọc được không ứng dụng này? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận thư này bằng tiếng Việt. Để được giúp đỡ miễn phí, xin gọi ngay số **1.888.421.8444 (toll-free)**.

GENERAL INFORMATION

Who can use this application	• You must live in Santa Clara County, California. • Do not complete this form if you qualify for financial assistance (federal help paying copayments, coinsurance, deductibles, or premiums). You can apply for coverage at **www.coveredca.com** through Covered California.
How to use this application	• If you want coverage for your family on the same plan, please complete one application for the family. • If a family member wants a different plan, he or she must complete a separate application.
Apply faster online	Visit **www.valleyhealthplan.org** to apply.

Application instructions

Please answer all questions. Type or print using black or blue ink. If your application is incomplete, it may delay your enrollment effective date.

SECTION 1

- Choose a plan.

Section 2

- If you are applying for individual coverage, complete the "Primary Applicant To Be Covered"

  If you are applying for family coverage on the same plan, complete the "Family Member to be Covered" section and the rest of Section 2 for your family members.

- If the primary applicant is a dependent under the age of 18, complete the "Primary Applicant To Be Covered" in Section 2 and "Parent or Legal Guardian" in Section 3. For additional dependents covered on the same VHP plan, complete the "Family Members(s) To Be Covered" in Section 2.

Section 3

- Complete for all dependents.

Section 4

- Complete if you are giving a trusted friend or partner permission to discuss this application with VHP.

Section 5

- Complete signatures as indicated.

Section 6

- How to pay your premium bill

Section 7

- Complete if you used an agent, broker, or VHP representative.

If you are using a paper application, send your completed and signed application to:

Valley Health Plan
2480 N. First Street, Suite 200
San Jose, CA 95131

Or fax to: VHP Member Services at **408.885.4425**

Need help with this application?

- For help completing this application, please call VHP Member Services at **1.888.421.8444 (toll-free)**.
- We will provide language assistance at no cost to you.
- If you have an agent or broker, please call him or her for help.

SECTION 1

Primary Applicant: _____

Please complete the following information. If any family members are applying for coverage under different plans, please submit a separate application form for each plan.

PLAN OPTIONS

Circle your plan choice name below:

Platinum 90 HMO	Gold 80 HMO	Silver 70 HMO	Bronze 60 HMO	Minimum Coverage

All plan options for the Individual & Family Plan include pediatric dental and vision benefits for those up to age 19.

MINIMUM COVERAGE PLAN

VHP also offers a Minimum Coverage Plan; 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.

MORE INFORMATION

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 (toll-free)** or contact your agent or broker.

SECTION 2

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. Complete the rest of **Section 2** for each family members.

☐ If this application is for a dependent under the age of 18, the dependent is the primary applicant.

☐ For additional dependents covered on the same plan, complete the "Family Member(s) Information" in this section.

SECTION 2 (continued)

PRIMARY APPLICANT TO BE COVERED (You must live in Santa Clara County)

Name (Last, First, Middle)			Member ID # (if any)
Street Address (No PO Boxes)			Apt#
City	State	Zip Code	County
Phone ( ) -		Other Phone ( ) -	
Email Address (if any)		Date of Birth MM / DD / YYYY	Sex Male ☐ Female ☐
VHP Primary Care Physician (PCP) Name (Last, First) (Refer to PCP List)			
Your Preferred Written Language (if not English)		Your Preferred Spoken Language (if not English)	

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

FAMILY MEMBER(S) TO BE COVERED (All members must live in Santa Clara County)

SPOUSE/DOMESTIC PARTNER

Name (Last, First, Middle)		Member ID # (if any)
Your Preferred Spoken Language (if not English)		Date of Birth MM / DD / YYYY
Your Preferred Written Language (if not English)		Sex Male ☐ Female ☐
VHP Primary Care Physician (PCP) Name (Last, First): (Refer to PCP list)		

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

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.

DEPENDENT 1

Name (Last, First, Middle)	Member ID # (if any)
Your Preferred Spoken Language (if not English)	Date of Birth MM / DD / YYYY
Your Preferred Written Language (if not English)	Sex ☐ Male ☐ Female
VHP Primary Care Physician (PCP) Name (Last, First) (Refer to PCP list)	

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

DEPENDENT 2

Name (Last, First, Middle)	Member ID # (if any)
Your Preferred Spoken Language (if not English)	Date of Birth MM / DD / YYYY
Your Preferred Written Language (if not English)	Sex ☐ Male ☐ Female
VHP Primary Care Physician (PCP) Name (Last, First) (Refer to PCP list)	

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

DEPENDENT 3

Name (Last, First, Middle)	Member ID # (if any)
Your Preferred Spoken Language (if not English)	Date of Birth MM / DD / YYYY
Your Preferred Written Language (if not English)	Sex ☐ Male ☐ Female
VHP Primary Care Physician (PCP) Name (Last, First) (Refer to PCP list)	

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

DEPENDENT 4

Name (Last, First, Middle)	Member ID # (if any)
Your Preferred Spoken Language (if not English)	Date of Birth MM / DD / YYYY
Your Preferred Written Language (if not English)	Sex Male ☐ Female ☐
VHP Primary Care Physician (PCP) Name (Last, First) (Refer to PCP list)	

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

DEPENDENT 5

Name (Last, First, Middle)	Member ID # (if any)
Your Preferred Spoken Language (if not English)	Date of Birth MM / DD / YYYY
Your Preferred Written Language (if not English)	Sex Male ☐ Female ☐
VHP Primary Care Physician (PCP) Name (Last, First) (Refer to PCP list)	

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

DEPENDENT 6

Name (Last, First, Middle)	Member ID # (if any)
Your Preferred Spoken Language (if not English)	Date of Birth MM / DD / YYYY
Your Preferred Written Language (if not English)	Sex Male ☐ Female ☐
VHP Primary Care Physician (PCP) Name (Last, First) (Refer to PCP list)	

Ethnicity (optional)

☐ Asian Indian ☐ Hispanic or Latino
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Russian
☐ Other _____

Race (optional)

☐ American Indian/Alaskan Native ☐ White
☐ Black/African-American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial
☐ Other _____

SECTION 3

A parent or legal guardian should complete this section if the primary applicant is a dependent under the age of 18.

PARENT OR LEGAL GUARDIAN

Name (Last, First, Middle)			
Same Address as Primary Applicant: ☐ Yes ☐ 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)			
Parental/Legal Guardian Date of Birth MM / DD / YYYY		Parent/ Legal Guardian Sex Male ☐ Female ☐	
Your Preferred Spoken Language (if not English)		Your Preferred Written Language (if not English)	

SECTION 4

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.

Name (Last, First, Middle)			
Same Address as Primary Applicant: ☐ Yes ☐ No		If No, fill in your address below:	
Street Address (No PO Boxes)			Apt#
City	State	Zip Code	County
Phone ( ) -		Other Phone ( ) -	
Your Preferred Spoken Language (if not English)		Your Preferred Written 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.

X _____ _____

Primary applicant or parent or legal guardian for applicants under age 18 *Date (MM/DD/YYYY)*

SECTION 5

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.

APPLICATION 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 Member Services at **1.888.421.8444 (toll-free)**.

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/oftlce/file** or **www.healthhelp.ca.gov** or **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.

ACKNOWLEDGMENTS 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 MM / DD / YYYY
Spouse/Domestic Partner	Date MM / DD / YYYY
Dependent (age 18 or older)	Date MM / DD / YYYY
Dependent (age 18 or older)	Date MM / DD / YYYY
Dependent (age 18 or older)	Date MM / DD / YYYY
Dependent (age 18 or older)	Date MM / DD / YYYY

HOW TO PAY YOUR PREMIUM BILL

You are responsible for submitting your monthly membership fees or Premiums directly to Valley Health Plan. Members are entitled to coverage under this Agreement once VHP has received the appropriate Premium payment. Coverage will be effective only for the period for which VHP received payment. **Payment must be postmarked or paid online no later than four (4) business days prior to the first day of the month you are eligible to receive services**. **Please make payment payable to "Valley Health Plan".** If you have questions regarding information on the method, amount, or frequency of your Premium(s), please contact VHP Member Services at **1.888.421.8444 (toll-free)**.

Upon receiving of your premium bill, mail payment directly to:
Valley Health Plan
County of Santa Clara
PO Box 740300
Los Angeles, CA 90074-0300

or

If using an Overnight Mail Service, mail payment to:
Valley Health Plan
Los Angeles Lockbox
Bank of America Lockbox Services
PO Box 740300 Ground Level 1000 W Temple St
Los Angeles, CA 90012

or

For online payments:
Go to **www.valleyhealthplan.org/paybill** to pay by credit card, debit card, or eCheck.

SECTION 7

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 VHP 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 subject 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** or ☐ **No**

Agent/Broker/VHP Representative Signature		Date MM / DD / YYYY
Agent/Broker/VHP Representative Name (Last, First, Middle) Knauss, Kevin		
Agent or Broker CA DOI Identification Number 0H12644		
Street Address (No PO Boxes) 8712 Pendleton Drive		
City Granite Bay	State CA	Zip Code 95746
Phone (916) 521 - 7216	Fax ( ) -	
Email Address (if any) kevin@insuremekevin.com		

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