Primary Applicant Name: _____

☐ New Coverage Plan Year: _____

☐ Add Dependent Main Subscriber ID: _____

☐ Change Coverage Main Subscriber ID: _____

# 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)。

**Հ այ ե ր ե ն (Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խո ս ո ւ մ ես հ այ ե ր ե ն , ապա ձե զ ան վ ճ ար կ ար ո ղ ե ն տր ամ ադ ր վ ե լ լ ե զ վ ակ ան աջ ակ ց ո ւ թյ ան ծ առ այ ո ւ թյ ո ւ ն ն ե ր : Զան գ ահ ար ե ք 1.888.421.8444 (California Relay Service (CRS) 711):

**Р ус с ки й (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**

**ف ارسی (Farsi)**

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

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)**

ਧਿਆਨ 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।

**لعبية (Arabic)**

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

**(Hindi)**

ान द : ियद आप ंहदी बोलते ह तो आपके लए मु म भाषा सहायता सेवाएं उपल ह ।

1.888.421.8444 (California Relay Service (CRS) 711) पर कॉल कर ।

ภาษาไทย **(Thai)**

เรียน: ถ☒าคุณพูดภาษาไทยคุณสามารถใช☒บริการช☒วยเหลือทางภาษาได☒ฟรี โทร

1.888.421.8444 (California Relay Service (CRS) 711).

**ខ្មែរ (Cambodian)**

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយឥនកភាសា ដោយមិនគិតឈ្ន
ល គឺអាចមានសំរាប់បើអ្នក។ ចូរ ទូរស័ព្ទ 1.888.421.8444 (California Relay Service
(CRS) 711).

**ພາສາລາວ (Lao)**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.888.421.8444 (California Relay Service (CRS) 711).

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

| | |
|---|---|
| **Who can use this application?** | • All applicants on this application **MUST** live in approved market area.<br>• If you qualify for financial assistance (federal help payment copayments, coinsurance, deductibles, or premiums), apply for coverage at www.coveredca.com through Covered California. |
| **How to submit this application?** | 1. Complete the application and print all pages<br>2. Submit completed application and required documents by:<br><br>Secure Fax: **408.947.4252**<br><br>In-Person or by Mail:<br><br>Valley Health Plan<br>Attn: Sales & Broker Relations<br>2480 North 1st St, Suite 160<br>San Jose, CA 95131 |
| **How to make your first payment?** | Once you've received your invoice by mail, you may send a check or money order along with payment stub to Valley Health Plan's payment center:<br>Please make check payable to **VALLEY HEALTH PLAN**<br><br>MAIL TO:<br><br>**STANDARD MAIL**<br>County of Santa Clara Valley Health Plan<br>PO Box 8884335<br>Los Angeles, CA 90088-8435<br><br>**OVERNIGHT MAIL**<br>Lockbox Services - #0138435<br>County of Santa Clara Valley Health Plan<br>3440 Flair Drive<br>El Monte, CA 91731<br><br>PAY VIA PHONE:<br>Contact Member Services Monday through Friday 8 a.m. – 5 p.m. PST at **1.888.421.8444,** closed on observed County holidays.<br>You may pay by **credit card, debit card or eCheck**,<br><br>PAY ON-LINE:<br>www.ValleyHealthPlan.org/paybill<br>You may pay by **credit card, debit card or eCheck**, |
| **When will coverage become effective?** | During **Open Enrollment**, coverage effective date will be on **January 1st**, after we've received your first premium payment. **During Special Enrollment Period**, coverage effective date corresponds to the qualifying life event. Please refer to the Special Enrollment section for more details. |
| **Need help completing this application?** | • For help completing this application, please call VHP Sales & Broker Relations at **408.885.3560**.<br>• If you have an agent or broker, please contact them for assistance. |

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

**SPECIAL ENROLLMENT PERIOD (Skip this section during Open Enrollment)**

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

Applications submitted during the **Special Enrollment Period**, require the applicant to be eligible to enroll and provide supporting documentation of a qualifying life event. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay your monthly premium do not constitute qualifying events.

**Unless otherwise noted below,** coverage date is based on when VHP received your completed application with all requested documentation. VHP will do its best to expedite the processing of your application.

| QUALIFYING LIFE EVENT (select one) | | | DOCUMENTATION | COVERAGE EFFECTIVE DATE |
|---|---|---|---|---|
| **Change in family size** | ○ | **Birth, Adoption or Foster Care**<br><br>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 | ☐ 1st day of the month after the event date<br>☐ 1st day of the month after a completed application is received<br>☐ Date:_____ |
| | ○ | **Marriage, Divorce or Legal Separation** | Filed court documents, notarized/legal termination of domestic partnership | ☐ 1st day of the month after we receive your completed application<br>☐ Date:_____ |
| | ○ | **Death of an Enrollee**<br><br>Death of a family member enrolled under current coverage. | Death certificate or obituary | ☐ 1st day of the month after a completed application is received<br>☐ Date:_____ |
| | ○ | **Court Order Mandate**<br><br>Required by a court order to provide eligible child(ren) coverage. | Court order | ☐ 1st day of the month after a completed application is received<br>☐ Date:_____ |
| **Change or Loss of health coverage** | ○ | **Employer-sponsored**<br><br>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 a completed application is received<br>☐ Date:_____ |
| | ○ | **Other Programs (i.e. Medi-Cal, COBRA, Covered CA, IHSS, Healthy Families, etc.)**<br><br>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,<br><br>Letter that provides notice of termination of COBRA or state continuation benefits. | ☐ 1st day of the month after VHP receives your completed application<br>☐ Date:_____ |

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

| QUALIFYING LIFE EVENT (select one) | | | DOCUMENTATION | COVERAGE EFFECTIVE DATE |
|---|---|---|---|---|
| **Change in residence** | ○ | **Moved to approved market area**<br><br>Permanent move from another country, state or county. | Proof of residency:<br><br>• Recent utility bill<br>• Signed lease, rental, mortgage or assisted living facility agreement<br>• A deed of property ownership<br>• New driver's license or state ID<br>• Property tax receipt<br>• Insurance documents<br>• Mail from DMV<br>• Official school documents<br>• Mail from a government agency<br>• Mail from a financial institution<br>• Employment document or Pay stub with address<br>• Voter registration card<br>• Medical document<br>• Letter of Residency Self-Attestation<br>• If homeless or in transitional housing, a letter from another resident of the same state, certifying they know where you live.<br>• If living in someone else's home, a statement from that person certifying you're living with them. | ☐ 1st day of the month after a completed application is received<br>☐ Date:_____ |

# 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 |
|---|---|---|---|---|
| ◯ Minimum Coverage Plan | ◯ Bronze 60 HMO | ◯ Silver 70 HMO | ◯ Gold 80 HMO | ◯ 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 out-of-pocket expenses 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

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Home Address** (No PO Boxes) | | **Mailing Address** (Leave blank if same as Home Address) |
| **City** / **State** / **ZIP** | | **City** / **State** / **ZIP** |
| **Primary Phone** | **Secondary Phone** | **Email** |
| **Date of Birth** (MM/DD/YYYY) | **Gender** ◯ Male ◯ Female | |
| **Your Preferred Written Language** (if not English) | | **Your Preferred Spoken Language** (if not English) |

**Ethnicity** (optional)

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Hispanic or Latino
- ☐ Vietnamese
- ☐ Russian
- ☐ Other_____

**Race** (optional)

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

**VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List

**Current patient?** ☐ Yes ☐ No

### SPOUSE OR DOMESTIC PARTNER

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Relationship to Primary Applicant** ☐ Spouse ☐ Domestic Partner | **Date of Birth (MM/DD/YY)** | **Gender** ☐ Male ☐ Female |

**Ethnicity** (optional)

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Hispanic or Latino
- ☐ Vietnamese
- ☐ Russian
- ☐ Other_____

**Race** (optional)

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

**VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List

**Current patient?** ☐ Yes ☐ No

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 2 – COMPLETE APPLICANT(S) INFORMATION

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 over-age dependent, the dependent's disability must start before the end of the period they would become ineligible for coverage.

### DEPENDENT 1

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Relationship to Primary Applicant**<br>☐ Child ☐ Other_____ | **Date of Birth (MM/DD/YY)** | **Gender**<br>☐ Male ☐ Female ☐ Other:_____ |
| **Ethnicity** (optional)<br>☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Hispanic or Latino ☐ Vietnamese ☐ Russian ☐ Other_____ | | Race (optional)<br>☐ American Indian/Alaskan Native ☐ Black/African-American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Asian ☐ Multi-Racial ☐ Other_____ |
| **VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List | | **Current patient?**<br>☐ Yes ☐ No |

### DEPENDENT 2

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Relationship to Primary Applicant**<br>☐ Child ☐ Other_____ | **Date of Birth (MM/DD/YY)** | **Gender**<br>☐ Male ☐ Female |
| **Ethnicity** (optional)<br>☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Hispanic or Latino ☐ Vietnamese ☐ Russian ☐ Other_____ | | **Race** (optional)<br>☐ American Indian/Alaskan Native ☐ Black/African-American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Asian ☐ Multi-Racial ☐ Other_____ |
| **VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List | | **Current patient?**<br>☐ Yes ☐ No |

### DEPENDENT 3

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Relationship to Primary Applicant**<br>☐ Child ☐ Other_____ | **Date of Birth (MM/DD/YY)** | **Gender**<br>☐ Male ☐ Female |
| **Ethnicity** (optional)<br>☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Hispanic or Latino ☐ Vietnamese ☐ Russian ☐ Other_____ | | **Race** (optional)<br>☐ American Indian/Alaskan Native ☐ Black/African-American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Asian ☐ Multi-Racial ☐ Other_____ |
| **VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List | | **Current patient?**<br>☐ Yes ☐ No |

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 2 – COMPLETE APPLICANT(S) INFORMATION

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 over-age dependent, the dependent's disability must start before the end of the period they would become ineligible for coverage.

### DEPENDENT 4

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Relationship to Primary Applicant**<br>☐ Child ☐ Other_____ | **Date of Birth (MM/DD/YY)** | **Gender**<br>☐ Male ☐ Female |
| **Ethnicity** (optional)<br>☐ Asian Indian ☐ Vietnamese<br>☐ Chinese ☐ Russian<br>☐ Filipino ☐ Other_____<br>☐ Hispanic or Latino | | Race (optional)<br>☐ American Indian/Alaskan Native ☐ White<br>☐ Black/African-American ☐ Asian<br>☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial<br>☐ Other_____ |
| **VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List | | **Current patient?**<br>☐ Yes ☐ No |

### DEPENDENT 5

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Relationship to Primary Applicant**<br>☐ Child ☐ Other_____ | **Date of Birth (MM/DD/YY)** | **Gender**<br>☐ Male ☐ Female |
| **Ethnicity** (optional)<br>☐ Asian Indian ☐ Vietnamese<br>☐ Chinese ☐ Russian<br>☐ Filipino ☐ Other_____<br>☐ Hispanic or Latino | | **Race** (optional)<br>☐ American Indian/Alaskan Native ☐ White<br>☐ Black/African-American ☐ Asian<br>☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial<br>☐ Other_____ |
| **VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List | | **Current patient?**<br>☐ Yes ☐ No |

### DEPENDENT 6

| **First Name** | **Middle Name** | **Last Name** |
|---|---|---|
| **Relationship to Primary Applicant**<br>☐ Child ☐ Other_____ | **Date of Birth (MM/DD/YY)** | **Gender**<br>☐ Male ☐ Female |
| **Ethnicity** (optional)<br>☐ Asian Indian ☐ Vietnamese<br>☐ Chinese ☐ Russian<br>☐ Filipino ☐ Other_____<br>☐ Hispanic or Latino | | **Race** (optional)<br>☐ American Indian/Alaskan Native ☐ White<br>☐ Black/African-American ☐ Asian<br>☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial<br>☐ Other_____ |
| **VHP Primary Care Physician** (Last, First & Address) – Refer to Provider List | | **Current patient?**<br>☐ Yes ☐ No |

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 3– 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 their behalf. The applicant or their 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, VHP 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 is not 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 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 At, 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** (MM/DD/YY) |
| **Spouse/Domestic Partner** | **Date** (MM/DD/YY) |
| **Dependent 1** (age 18 and older) | **Date** (MM/DD/YY) |
| **Dependent 2** (age 18 and older) | **Date** (MM/DD/YY) |
| **Dependent 3** (age 18 and older) | **Date** (MM/DD/YY) |
| **Dependent 4** (age 18 and older) | **Date** (MM/DD/YY) |

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 4– PARENT OR LEGAL GUARDIAN INFORMATION

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

| **First Name** | **Middle Name** | | **Last Name** |
|---|---|---|---|
| **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** | | **Email** | |
| **Gender** ☐ **Male** ☐ **Female** | | **Parent/Legal Guardian Date of Birth (MM/DD/YY)** | |
| **Your Preferred Written Language** (if not English) | | **Your Preferred Spoken Language** (if not English) | |

# INDIVIDUAL & FAMILY PLAN ENROLLMENT APPLICATION

## SECTION 5– AUTHORIZED PERSONAL REPRESENTATIVE INFORMATION

Complete this section if you would like another person to act as your Authorized Representative.

**YOU MAY CHOOSE AN AUTHORIZED PERSONAL 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.

| | | | |
|---|---|---|---|
| **First Name** | **Middle Name** | | **Last Name** |
| **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 Written Language** (if not English) | | **Your Preferred Spoken Language** (if not English) | |

By signing, you allow this person to sign your application, obtain 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/CERTIFIED ENROLLER/VHP REPRESENTATIVE**

**FOR APPLICANTS USING AN AGENT/BROKER/VHPREPRESENTATIVE**

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, CERTIFIED ENROLLER 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/Certified Enroller/VHP Representative Signature** | | **Date** (MM/DD/YY) |
|---|---|---|
| **Agent/Broker/Certified Enroller/VHP Representative Name** (First, Last) | **Agency/Organization** | |
| **Agent or Broker CA DOI Identification Number/Enroller ID** | **Federal Tax ID** | |
| **Street Address** (No PO Boxes) | | |
| **City** | **State** | **Zip Code** |
| **Phone** | **Fax** | |
| **Email Address** | | |