



The University of Alabama at Birmingham  
Medical Center Student Health

**PLEASE MAIL APPLICATION AND PAYMENT TO:**

Student Health Services  
1714 9<sup>th</sup> Avenue South, 3<sup>rd</sup> Floor  
Birmingham, AL 35294-1270

**Application for UAB Student Health Plan Six-Month Continuation**

(Do not complete this form if you desire Optional/Undergraduate Student Insurance or if you are signing a waiver. This is to be completed only if you are enrolled in one of the schools listed below that mandates health insurance.)

Today's Date:	BOO#:
Date Requesting Coverage:	Member Number (Office Use Only):

**PERSONAL INFORMATION**

Students First Name:	Students Middle Name:	Students Last Name:
Address:	City:	State: Zip Code:
Home Phone:	EMAIL ADDRESS:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	Blazer ID:	Social Security Number:
Semester: <input type="checkbox"/> Fall Semester <input type="checkbox"/> Spring Semester <input type="checkbox"/> Summer Semester <input type="checkbox"/> Other _____		
Coverage Desired: <input type="checkbox"/> Student Only <input type="checkbox"/> Student & Spouse <input type="checkbox"/> Student, Spouse & Child(ren)		

**DEPENDENTS TO BE COVERED**

Please complete the following for any person(s) to be covered. Please be sure to select a Personal Care Physician for any dependents to be covered. If more than 2 children will be covered, attach an additional page with the requested information.

First	MI	Last	SS #	Sex	Date of Birth	Personal Care Provider (PCP)
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F		
Child				<input type="checkbox"/> M <input type="checkbox"/> F		
Child				<input type="checkbox"/> M <input type="checkbox"/> F		

After coverage becomes effective with VIVA HEALTH, will you or any dependents listed above be covered by any other medical insurance or health plan including Medicare or another VIVA HEALTH plan?      YES      NO

If yes, what type of coverage:  Spouse's Employer  COBRA  Medicare  Medicaid  Other \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

**MEMBERSHIP CONDITIONS**

I desire coverage by VIVA Health Student Health Plan to become effective when I am officially enrolled. I understand that my insurance will be coverage for the semester for which I am enrolled and it will not be automatically renewed. I will be responsible for payment of premiums and renewal at the beginning of each semester for which I am still an eligible student. I will notify VIVA Health if I am no longer a student. I (we) authorize the release and use of all my (our) medical records or information necessary for payment, treatment, or health care operations. Medical information can also be used to execute the obligations imposed on VIVA Health by state or federal statutes, as well as for the Quality Assurance or Peer Review programs conducted by VIVA Health or its designated agents. Pediatric dental coverage is a required essential health benefit mandated by the Affordable Care Act. By signing this application for medical coverage from VIVA Health, you are also agreeing to purchase pediatric (children up to age 19) dental coverage. UAB and VIVA Health have entered into agreement with Delta Dental Insurance Company to provide the required coverage under the Delta Dental Plan 70 for Children. Although this is a separate policy, monthly dental premiums are included in your VIVA Health rates and will be remitted by VIVA Health on your behalf to Delta Dental as part of your monthly premiums to VIVA Health.

**X** \_\_\_\_\_  
STUDENT SIGNATURE

\_\_\_\_\_  
DATE

**Fraud Warning**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to loss of insurance coverage, restitution, fines, confinement in prison, or any combination thereof.

Date	Charge