The University of Alabama at Birmingham
Medical Center Student Health

PLEASE MAIL APPLICATION AND PAYMENT TO:
Student Health Services
1714 9th Avenue South, 3rd Floor
Birmingham, AL 35294-1270

Application for VIVA HEALTH Mandatory Student Health Plan

(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: D Male D Female
Date of Birth:	Blazer ID:	Social Security Number:	

Semester: D Fall Semester D Spring Semester D Summer Semester D Other _____

School or College in which you are enrolling (Check One):
DMedical DDental DOptometry DNursing DHealth Related Professions
DPublic Health DGraduate (Degree Seeking) DInternational Student DInternational Scholar

Coverage Desired: D Student Only D Student & Spouse D 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		D M D F		
Child		D M D F		
Child		D M D 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: D Spouse's Employer D COBRA D Medicare D Medicaid D 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.

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For Student Health Office Use Only

Date	Charge

UABMANDAPP2017-2018