The University of Alabama at Birmingham
Medical Center Student Heal

Application for VIVA HEALTH Optional Student Health Plan

PLEASE MAIL APPLICATION AND PAYMENT TO:
VIVA HEALTH, Inc. Attn: Enrollment
417 20th Street North Suite 1100. Birmingham, AL 35203

COVERAGE DATES: ☐ Fall Semester ☐ Spring Semester ☐ Summer Semester

[2016-2017] SEMESTER PREMIUMS:

FALL: STUDENT: [$780] SPOUSE: [$780] FIRST CHILD: [$780] ADD'L CHILD: [$780]
SPRING: STUDENT: [$975] SPOUSE: [$975] FIRST CHILD: [$975] ADD'L CHILD: [$975]
SUMMER: STUDENT: [$585] SPOUSE: [$585] FIRST CHILD: [$585] ADD'L CHILD: [$585]

PERSONAL INFORMATION

Students First Name:	**Students Middle Name:**		**Students Last Name:**
Address:	**City:**	**State:**	**Zip Code:**
Home Phone:	**EMAIL ADDRESS:**		**Boo#**
Date of Birth:	**Blazer ID:**	**Social Security number**: __ __ __-__ __-__ __ __ __	

Requirements:

1. Full-time Undergraduate students (12 hours) and non-health related graduate students (5 hours) 2. Citizenship – any except Non-Resident Alien
3. Students must actively attend classes for at least the first 31 days after the date for which the coverage is purchased.
4. Optional Insurance is applied for and prepaid by the semester. 5. An application must be completed each semester, along with a copy of your registration schedule.
6. Payment and application must be received no later than 3 days after the deadline for adding classes each semester

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		☐ M ☐ F		
Child		☐ M ☐ F		
Child		☐ M ☐ 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: _____

PAYMENT METHOD (Indicate Applicable Payment)

Payment Instructions: **Mail In Option: Make check or money order payable to VIVA HEALTH, in US dollars or refer to the Credit Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment form along with premium payment. Your cancelled check or credit card billing is your receipt and notification of coverage. VIVA HEALTH will send a renewal notice of premium due to the address on file. It is important that the student make timely renewal payments to avoid a lapse in coverage. VIVA HEALTH will NOT accept cash payments.**

CREDIT CARD AUTHORIZATION (processing fee $20.00)
Total to Charge $_____ **VISA/MC** _____ **Expiration Date**_____/_____
Cardholder Name _____ **Signature of Cardholder**_____

CHECK OR MONEY ORDER (ENCLOSED) TOTAL AMOUNT $_____

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.