VIVA HEALTH

UNIVERSITY OF SOUTH ALABAMA

ACCESS ENROLLMENT/STATUS CHANGE FORM

☐ New Enrollment ☐ Re-Enrollment ☐ Change Information ☐ Request Termination

Show Reason for Change:	☐ Address Change	☐ COBRA	☐ Single to Family	**Primary Language:**
☐ Marriage	☐ Employment Terminated	☐ Open Enrollment		☐ English
☐ Birth/Adoption	☐ Not An Eligible Employee	☐ Name Change		☐ Spanish
☐ Moved Out-of-Area	☐ Not An Eligible Dependent	☐ Family to Single		☐ Other
Employee Name: *(Last, First, Middle Initial)*				**Hire Date:**

Home Address:	**Apt. Number:**	**City:**	**State:**	**Zip Code:**

Home Telephone Number: ( )	**Work Telephone Number:** ( )	**Employer:**	**Division Location:**

DEPENDENTS TO BE COVERED

Individuals listed below may include those eligible according to the Certificate of Coverage. Additional information may be required if spouse and/or children do not have the same last name as the employee (i.e., birth or marriage certificate)

Name of Person to be Covered **Last First MI**	**Social Security Number**	**Sex**	**Date of Birth**
Employee		☐ M ☐ F	
Spouse [1]Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child [1]Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child [1]Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child [1]Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	
Child [1]Resides with Employee ☐ Yes ☐ No		☐ M ☐ F	

[1]Coverage will not be offered to dependents living outside the service area. The service area is defined as the state of Alabama. If you are subject to a court decree to provide health coverage for any dependent(s) listed above, please provide a copy of the decree.

Are you presently covered on a health insurance plan? ☐ Yes ☐ No **If yes,** how long has this coverage been continuous? ____________________

If yes, what type of coverage: ☐ Spouse's Coverage ☐ COBRA ☐ Present Employer's Coverage ☐ Medicare/Medicaid ☐ Other _____________

Name of Present Insurance Company: ________________________________ Name of Policy Holder: _____________________________________

Policy # or Medicare #: ______________________________________ Address of Insurance Company: ___________________________________

After coverage becomes effective with VIVA HEALTH, Inc., are you or any family members to be covered by another medical insurance or Medicare?
☐ Yes ☐ No

EMPLOYER VERIFICATION			
Employer Signature: ____________________	**Group Number:**	**Employment Date:**	**Effective Date:**

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MEMBERSHIP CONDITIONS

I am aware of and accept the following VIVA HEALTH, Inc. membership conditions:

1. I understand that the USA VIVA HEALTH & Dental Plan is a limited network plan and the service area is defined as the state of Alabama.

2. I authorize the release and use of all my medical records or information necessary to process claims or in any way determine benefits due. Medical information can also be used to execute the obligations imposed on VIVA HEALTH, Inc. by state or federal status, as well as for the Quality Assurance or Peer Review programs conducted by Viva Health, Inc. or its designated agents.

3. I authorize my employer to deduct premium contributions, if any, from my wages or salary with the understanding that my employer acts as my agent in all dealings with the Plan where not prohibited by statute or regulation.

4. I have read and understand the membership information available in the enrollment materials including the description of exclusions and limitations. I will abide by the Group Health Policy and Certificate of Coverage applicable to the plan in which I enrolled, and will be responsible for ensuring my (our) dependents follow instructions and abide by conditions listed therein.

5. I understand any service not provided by a participating physician or authorized by VIVA HEALTH, Inc. will not be covered and will be my responsibility.

6. I understand that the USA VIVA HEALTH & Dental Plan is a limited network plan that does not provide benefits for out-of-network medical providers except in the case of emergency medical care and then only after proper notification. I understand that it is my responsibility to ensure that medical care is provided by a Network Provider. I understand that I may not change from the USA VIVA HEALTH & Dental Plan except during open enrollment for coverage effective January 1 of the following year.

7. I understand that if I am currently a USA Health & Dental Base Plan participant and I voluntarily elect to participate in the USA VIVA Health & Dental Plan; and should I elect later to change from the USA VIVA Health & Dental Plan, I understand that I may only re-enroll in the USA Health & Dental Standard Plan.

TOBACCO USE CERTIFICATION

The USA VIVA Health & Dental Plan is committed to helping you achieve your best health. The Wellness Incentive is available to all employees. If you think you might be unable to meet the standard under this Wellness Program, you may qualify for an opportunity to earn the same reward by different means. Contact the USA Human Resources Department for additional information.

Have you or your spouse used tobacco products within the last six (6) months? ___ YES ___ NO

Further, I attest that everything in the application is true.

Printed name_______________________________ **Employee J#**__________________

Signature: ______________________________________ **Date:** _________________________