



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.)

DATE: ____/____/____

Student's ID/Social Security #:		Telephone #:	E-mail Address:
Student's Last (Family) Name:		Student's First Name:	Middle Initial:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date: / /	
Street Address:			
City:		State:	Zip Code:
Semester: <input type="checkbox"/> Fall Semester <input type="checkbox"/> Spring Semester <input type="checkbox"/> Summer Semester <input type="checkbox"/> Other _____			
School or College in which you are enrolling (Check one):			
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optometry <input type="checkbox"/> Nursing <input type="checkbox"/> Health Related Professions <input type="checkbox"/> Public Health <input type="checkbox"/> Graduate (Degree Seeking) <input type="checkbox"/> International Student <input type="checkbox"/> International Scholar			
Coverage Desired: <input type="checkbox"/> Student Only <input type="checkbox"/> Student & Spouse <input type="checkbox"/> Student, Spouse & Child(ren)			

Please be sure to choose a Personal Care Provider for any spouse or children added to the plan.

RELATIONSHIP (CHECK ONE):	SEX	FULL NAME			BIRTH DATE	PERSONAL CARE PROVIDER (PCP)
		LAST (FAMILY)	FIRST	MI		
SPOUSE	<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /	
CHILD	<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /	
CHILD	<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /	
CHILD	<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /	
CHILD	<input type="checkbox"/> Male <input type="checkbox"/> Female				/ /	

I desire coverage by VIVA HEALTH Student Health Plan to become effective when I am officially enrolled. I understand that my insurance will remain active for the entire UAB academic school year. I understand that it will be **Automatically Renewed** at the beginning of the next UAB academic year if I remain eligible. I will be responsible for payment of premiums. I will notify Student Health Services when I am no longer a student. I (we) authorize the release and use of all my (our) 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 statutes, as well as for the Quality Assurance or Peer Review programs conducted by VIVA HEALTH, Inc. or its designated agents.

STUDENT SIGNATURE: _____

DATE: _____

EFFECTIVE DATE: _____

For Office Use Only

DATE	CHARGE	CODED	DATE	CHARGE	CODED