UNIVERSITY OF VIRGINIA HEALTH PLAN, DENTAL PLAN AND DAVIS VISION ENROLLMENT APPLICATION

1. EMPLOYMENT STATUS – CHECK ALL THAT APPLY

☐Medical Center ☐Retiree ☐Retiree Spouse/Dependent ☐PostDoctoral Fellow ☐HouseStaff

If Spouse or Dependent of Retiree, provide Name and SS# of UVA Retiree _____

2. WAIVE COVERAGE – SELECT PLAN(S) YOU WISH TO WAIVE COVERAGE

☐**HEALTH PLAN** ☐**DENTAL PLAN** ☐**DAVIS VISION**

☐**Active Employees:** I do not wish to enroll in the UVA Health Plan, Dental Plan, or Davis Vision that I selected above in this section. I understand that I may elect coverage during open enrollment or after a mid-year qualifying event.

☐**Retirees:** I do not wish to enroll in the UVA Health Plan, Dental Plan, or Davis Vision that I selected above in this section. I understand that once I waive coverage, there is no option for reinstatement.

Print Name _____

Signature _____Social Security Number _____Date _____

3. REASON APPLICATION IS BEING SUBMITTED – DOCUMENTATION VERIFYING DEPENDENT ELIGIBILITY IS REQUIRED

☐Open Enrollment Period

☐Addition ☐Deletion ☐New Enrollee ☐Late Enrollee

☐New Hire: Date of Employment_____

☐Retirement: Date of Retirement or Date of Spouse's Medicare Eligibility_____

☐Mid-year Qualifying Event: Date of Mid-year Qualifying Event_____

Additions **(Appropriate documentation required. Please attach)**

- ☐Birth/Adoption of Child
- ☐Marriage
- ☐Department of Social Services Health Care Coverage Order
- ☐Termination of Employment by the Employee's spouse/child
- ☐Other (Please list qualifying event): _____

Deletions **(Appropriate documentation required. Please attach)**

- ☐Loss of dependent eligibility
- ☐Divorce
- ☐Death of spouse or child
- ☐Department of Social Services Health Care Coverage Order
- ☐Commencement of Employment by the Employee's spouse/child
- ☐Other (Please list qualifying event): _____

4. APPLICANT INFORMATION

Last Name	First Name	Middle Initial	Social Security Number

Street Address	City	State	Zip Code

Home Phone Number ( )	Cell Phone Number ( )	Marital Status ☐Single ☐Married	Email Address:

5. UVA HEALTH PLAN

- Post-Doc and HouseStaff are not eligible for Basic Health
- J1 Visa Holders are only eligible for Choice Health

☐Choice Health ☐Value Health ☐Basic Health

6. TYPE OF MEMBERSHIP

☐Participant Only ☐Participant + Spouse ☐Participant + Child(ren) ☐Family

7. UVA DENTAL PLAN

- Post-Doc and HouseStaff are not eligible for Enhanced Dental

☐Enhanced Dental ☐Basic Dental

8. TYPE OF MEMBERSHIP

☐Participant Only ☐Participant + Spouse ☐Participant + Child(ren) ☐Family

9. DAVIS VISION

- Retirees and PostDocs are not eligible for Davis Vision

☐Davis Vision

10. TYPE OF MEMBERSHIP

☐Participant Only ☐Participant + Spouse ☐Participant + Child(ren) ☐Family

11. APPLICANT/SPOUSE/DEPEDENT DATA

Please enter information for yourself and all family members you want to enroll in the UVA Health Plan, Dental Plan, and/or Davis Vision. If adding or removing dependents and/or spouse, **enter only information for those who are being added or removing.**

Relationship	Name, Social Security Number	Birthdate	(Check All That Apply)
☐Applicant	Last, First, Middle Initial	Month Day Year	☐Health Plan ☐Dental Plan ☐Davis Vision
	Social Security Number	Sex ☐F ☐M	
☐Spouse	Last, First, Middle Initial	Month Day Year	☐Health Plan ☐Dental Plan ☐ Davis Vision
	Social Security Number	Sex ☐F ☐M	
☐Child ☐Disabled Child * ☐Other **	Last, First, Middle Initial	Month Day Year	☐Health Plan ☐Dental Plan ☐ Davis Vision
	Social Security Number	Sex ☐F ☐M	
☐Child ☐Disabled Child * ☐Other **	Last, First, Middle Initial	Month Day Year	☐Health Plan ☐Dental Plan ☐ Davis Vision
	Social Security Number	Sex ☐F ☐M	

* Disabled children over the age of 26 must provide documents and be approved for enrollment **prior** to entry into the UVA Health Plan, Dental Plan, and Davis Vision. Contact the UHR Service Team to learn eligibility and documentation requirements.

** I confirm that I am the legal guardian with a court order to assume permanent custody of the "Other" child(ren) who live(s) with me full-time in a regular parent-child relationship and is (are) claimed on my Federal Tax returns.

Applicant Signature _____

12. APPLICANT SIGNATURE (sign below to accept coverage or sign Section #2 to waive coverage)

I apply for the UVA Health Plan, UVA Dental Plan, and/or Davis Vision enrollment for the persons listed, and agree that my family members and I shall be covered according to the terms of the plan. I hereby authorize deductions from my earnings of any required contributions, including reimbursement to the health and dental plans for ineligible claims paid on behalf of ineligible or eligible family members enrolled on my policy. I also authorize any licensed physician, dentist, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person who has legitimate needs for such information for the purpose of obtaining insurance or evaluation of a claim, to supply each other and the third party administrator or health plan with information about me or my family's health status and health care services provided to me or my family. In addition, I authorize the UVA Health Plan, UVA Dental Plan, and/or UVA Vision Plan and any other organization, institution, or person acting on the plan's behalf, to audit me and my family members' enrollment eligibility. I understand that health information about me or my family members created and maintained by the plan will be protected by federal privacy regulations under the Health Insurance Portability and Accountability Act ("HIPAA") and that I will receive a Notice of Privacy Practices that explains how HIPAA will protect our health information. I further understand that under the HIPAA privacy regulations, my health information and my family members health information created and maintained by the plan may be disclosed without our authorization to any licensed physician, dentist medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, Medical Information Bureau, or other organization, institution or person as permitted by HIPAA for "treatment, payment and health care operations" purposes, including follow-up health education, disease management, and improvement of the UVA Health Plan and its Hoo's Well program. A photographic copy of this authorization shall be as valid as the original. A copy of this authorization is available upon request to me or my authorized representative. This authorization is valid through the coverage period. To the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true, and I agree that they will be the basis of the issuance of any coverage. I will notify UVA promptly in writing concerning any changes in the above information.

Applicant Signature_____Date: _____

FOR EMPLOYER/GROUP USE ONLY

Reason:	Effective Date:	Control, Suffix, Account:		Employer Signature:
☐New Hire ☐Open Enrollment ☐Mid-Year Event	☐Oracle ☐PeopleSoft ID:_____	Health: _____ Dental: _____ Vision: _____	☐Health Plan: _____ ☐Dental Plan: _____ ☐Vision Plan: _____	Date:

Submit Completed form and documentation to:

University of Virginia
UHR Service Team
914 Emmet Street
PO Box 400127
Charlottesville, VA 22904-4127
Fax: (434) 924-4486