

**POSTDOCTORAL FELLOWS AND HOUSESTAFF UNIVERSITY OF VIRGINIA HEALTH PLAN AND DENTAL PLAN  
ENROLLMENT APPLICATION**

**1. STATUS – CHECK ALL THAT APPLY**

- House Staff     COBRA Housestaff     Postdoctoral Fellows     COBRA Postdoctoral Fellows

**2. WAIVE COVERAGE – UVA HEALTH PLAN**

I do not wish to enroll in the UVA Health Plan at this time. I understand that I may elect coverage during open enrollment or after a mid-year qualifying event.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Social Security # \_\_\_\_\_ Date \_\_\_\_\_

**3. WAIVE COVERAGE – UVA DENTAL PLAN**

I do not wish to enroll in the UVA Health Plan at this time. I understand that I may elect coverage during open enrollment or after a mid-year qualifying event.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Social Security # \_\_\_\_\_ Date \_\_\_\_\_

**4. REASON APPLICATION IS BEING SUBMITTED**

- Open Enrollment Period  
      Addition     Deletion     New Enrollee     Late Enrollee
- New Enrollee: Date of Fellowship or Residency \_\_\_\_\_
- Extended Coverage (COBRA): Date of Loss of Coverage \_\_\_\_\_ Reason for Loss of Coverage \_\_\_\_\_
- 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): \_\_\_\_\_

**5. TYPE OF MEMBERSHIP**

- Single     Postdoc/Housestaff + Spouse     Postdoc/Housestaff + Child(ren)  
 Family

**6. TYPE OF COVERAGE**

- Postdoctoral Fellow     HouseStaff  
 COBRA Postdoctoral Fellow  
 COBRA Housestaff

**7. APPLICANT INFORMATION**

Last Name		First Name		Middle Initial	Social Security Number	
Street Address			City		State	Zip Code
Home Phone Number (    )	Work Phone Number (    )		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Email Address:	

## 8. UVA HEALTH PLAN

Choice Health

Value Health

## 9. APPLICANT/SPOUSE/DEPENDENT DATA – UVA HEALTH PLAN

If new applicant, enter information for yourself and all family members you want to enroll in the UVA Health Plan. If adding or deleting dependents and/or spouse, **enter only information for those who are being added or deleted.**

Relationship	Name, Social Security Number	Birthdate
<input type="checkbox"/> Applicant	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Social Security Number	Mo. Day Year
<input type="checkbox"/> Spouse	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Social Security Number	Mo. Day Year
<input type="checkbox"/> Child <input type="checkbox"/> Disabled Child * <input type="checkbox"/> Other **	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Social Security Number	Mo. Day Year
<input type="checkbox"/> Child <input type="checkbox"/> Disabled Child * <input type="checkbox"/> Other **	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Social Security Number	Mo. Day Year

\* Disabled children over the age of 26 must provide documents and be approved for enrollment **prior** to entry into the UVA Health Plan. 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 \_\_\_\_\_

## 10. UVA DENTAL PLAN

Basic Dental

## 11. APPLICANT/SPOUSE/DEPENDENT DATA – UVA DENTAL PLAN

If new applicant, enter information for yourself and all family members you want to enroll in the UVA Dental Plan. If adding or deleting dependents and/or spouse, **enter only information for those who are being added or deleted.**

Relationship	Name, Social Security Number	Birthdate
<input type="checkbox"/> Applicant	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Social Security Number	Mo. Day Year
<input type="checkbox"/> Spouse	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Social Security Number	Mo. Day Year
<input type="checkbox"/> Child <input type="checkbox"/> Disabled Child * <input type="checkbox"/> Other **	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M
	Social Security Number	Mo. Day Year

<input type="checkbox"/> Child <input type="checkbox"/> Disabled Child * <input type="checkbox"/> Other **	Last, First, Middle Initial	Sex <input type="checkbox"/> F <input type="checkbox"/> M		
	Social Security Number	Mo.	Day	Year

\* Disabled children over the age of 26 must provide documents and be approved for enrollment **prior** to entry into the UVA Dental Plan. 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 and/or UVA Dental Plan 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 plan 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 and/or Dental 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 GROUP USE ONLY – UVA HEALTH PLAN**

<b>Reason for Submitting Application:</b>  <input type="checkbox"/> New Enrollee <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Mid-Year Qualifying Event	Effective Date of Coverage:	Oracle:	UVA Signature:
	Control , Suffix, Account	Plan	Date:

**FOR GROUP USE ONLY – UVA DENTAL PLAN**

<b>Reason for Submitting Application:</b>  <input type="checkbox"/> New Enrollee <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Mid-Year Qualifying Event	Effective Date of Coverage:	Oracle:	UVA Signature:
	Control , Suffix, Account	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**