UNIVERSITY OF VIRGINIA HEALTH PLAN AND DENTAL PLAN ENROLLMENT APPLICATION
This application is not for use by Postdoctoral Fellows or Housestaff.

1. EMPLOYMENT STATUS – CHECK ALL THAT APPLY

☐ Academic Division Staff/Faculty ☐ Academic Division Salaried Part Time ☐ UVa at Wise Staff/Faculty ☐ Medical Center ☐ Cobra ☐ Retiree ☐ Retiree, Spouse or Dependent

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

2. WAIVE COVERAGE – UVA HEALTH PLAN

☐ **Active Employees:** 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.

☐ **Retirees and COBRA:** I do not wish to enroll in the UVA Health Plan at this time. I understand that once I waive coverage, there is no option for reinstatement.

Print Name ______________________________

Signature ______________________Social Security # ______________ Date ______________

3. WAIVE COVERAGE – UVA DENTAL PLAN

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

☐ **Retirees and COBRA:** I do not wish to enroll in the UVA Dental Plan at this time. I understand that once I waive coverage, there is no option for reinstatement.

Print Name ______________________________

Signature ______________________Social Security # ______________ Date ______________

4. 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 ______________________

☐ Extended Coverage (COBRA): Date of Loss of Coverage ____________ Reason for Loss of Coverage ____________________

☐ 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): ______________________________

5. TYPE OF MEMBERSHIP

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

☐ Family

6. TYPE OF COVERAGE

☐ Active UVA Employee ☐ Cobra

☐ Retired/Disability

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 ☐ Single ☐ Married	Email Address:

8. UVA HEALTH PLAN

☐ Choice Health ☐ Value Health ☐ Basic 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		
☐ Applicant	Last, First, Middle Initial	Sex ☐ F ☐ M		
	Social Security Number	Mo.	Day	Year
☐ Spouse	Last, First, Middle Initial	Sex ☐ F ☐ M		
	Social Security Number	Mo,	Day	Year
☐ Child ☐ Disabled Child * ☐ Other **	Last, First, Middle Initial	Sex ☐ F ☐ M		
	Social Security Number	Mo.	Day	Year
☐ Child ☐ Disabled Child * ☐ Other **	Last, First, Middle Initial	Sex ☐ F ☐ 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

☐ Enhanced Dental ☐ 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		
☐ Applicant	Last, First, Middle Initial	Sex ☐ F ☐ M		
	Social Security Number	Mo.	Day	Year
☐ Spouse	Last, First, Middle Initial	Sex ☐ F ☐ M		
	Social Security Number	Mo,	Day	Year
☐ Child ☐ Disabled Child * ☐ Other **	Last, First, Middle Initial	Sex ☐ F ☐ M		
	Social Security Number	Mo.	Day	Year

☐ Child ☐ Disabled Child * ☐ Other **	Last, First, Middle Initial	Sex ☐ F ☐ 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 EMPLOYER/GROUP USE ONLY – UVA HEALTH PLAN

Reason for Submitting Application: ☐ New Hire ☐ Open Enrollment ☐ Mid-Year Qualifying Event	Effective Date of Coverage:	Oracle or PeopleSoft:	Employer Signature:
	Control , Suffix, Account	Plan	Date:

FOR EMPLOYER/GROUP USE ONLY – UVA DENTAL PLAN

Reason for Submitting Application: ☐ New Hire ☐ Open Enrollment ☐ Mid-Year Qualifying Event	Effective Date of Coverage:	Oracle or PeopleSoft:	Employer 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