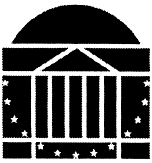

UNIVERSITY OF VIRGINIA HEALTH PLAN

Medical Claims Processing by:
Southern Health Services, Inc.

University Human Resources (UHR)
Office of University Benefits
914 Emmet Street
P.O. Box 400127
Charlottesville, Virginia 22904-4127
(434) 924-4392
(434) 924-4486 fax

UNIVERSITY OF VIRGINIA HEALTH BENEFITS

ENROLLMENT/CHANGE APPLICATION FOR UVA HEALTH PLAN

HOW TO ENROLL:

Please review these instructions before completing the Enrollment Application. If you have any questions regarding eligibility or enrollment, please contact the UHR Office of University Benefits at (434) 924-4392.

INSTRUCTIONS:

- Please print or type using black or blue ink.
- **New applicants** should complete the entire application.
- **To waive coverage,** complete sections 1 and 2.
- **For mid-year qualifying events,** complete sections 1 and 3-13. List only additions or deletions in Section 10. **Appropriate documentation MUST accompany this application.**
- **Active Employees:** Applications should be received within 60 days of the date of hire or a mid-year qualifying event. Those received after this 60-day timeframe but within the same plan year will be accepted. Only prospective coverage will be provided.
- **Retirees:** Applications associated with retirees, including initial enrollment in the retirement program, must be received within 31 days of the retirement date or mid-year qualifying event date. Those received after this deadline will be declined. Contact the UHR Office of University Benefits for specific enrollment information.
- **COBRA:** Applications associated with the mid-year qualifying events must be received within 31 days. Those received after this deadline will be declined. Contact the UHR Office of University Benefits for information and forms for initial enrollment.

RETURN COMPLETED APPLICATION:

Return the completed form to the UHR Office of University Benefits at 914 Emmet Street, P.O. Box 400127, Charlottesville, VA 22904-4127 or by fax at (434) 924-4486.

Completion and acceptance of this application will generate four ID cards; one from Southern Health Services for medical and mental health services (one card per participant), one from United Concordia for dental services (two cards per household), one from Caremark for pharmacy services (two cards per household) and one from Eye Benefits Inc. discounted vision services (one card per household).

UNIVERSITY OF VIRGINIA ENROLLMENT APPLICATION

1. EMPLOYMENT STATUS - CHECK ALL THAT APPLY

❑ Staff/Faculty ❑ Salaried Part Time ❑ Medical Center ❑ Retiree ❑ Retired Spouse or Dependent ❑ Cobra

If Retiree Spouse or Dependent, provide Name and SS# of UVA retiree: ____

2. WAIVE COVERAGE

❑ **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. REASON APPLICATION IS BEING SUBMITTED

❑ Open Enrollment Period

❑ Addition ❑ Deletion ❑ New Enrollee ❑ Late Enrollee

❑ New Hire: Date of Employment________________________

❑ Extended Coverage (COBRA): Date of 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
- ❑ Other (Please list qualifying event):________________________________

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

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

4. TYPE OF MEMBERSHIP	5. TYPE OF COVERAGE
❑ Participant only ❑ Participant + Spouse ❑ Participant + Child ❑ Family ❑ Family for Two Married State Employees with Children	❑ Active UVA Employee ❑ Retired/Disability ❑ Cobra

6. PREMIUM CONVERSION

Active UVA employees will automatically have their health premiums deducted from their paychecks using pre-tax dollars.

❑ **I DO NOT** want premium conversion I want my health premiums deducted from my paycheck using **after-tax** dollars.

❑ **I WANT** to change from using after-tax dollars to enrolling in premium conversion.

7. COMPLETE ONLY IF TWO MARRIED STATE EMPLOYEES IN FAMILY WITH AT LEAST ONE COVERED CHILD

To be eligible for this special family coverage, both spouses must be active full-time salaried employees or Medical Center part-time employees who signed flex agreements.

Date of Marriage:________________ Deduct premium from: ❑ Husband ❑ Wife

***Spouse paying for Family membership must read and sign this acknowledgement:**

I acknowledge full responsibility to repay any UVA contribution paid in error on my behalf due to my spouse's loss of eligibility.
(Spouse paying premium should complete UVA Health Plan enrollment application.)

Signature:____ Date:____________________

***Spouse NOT paying premium for membership must read and sign this waiver:**

I will not enroll in separate coverage of my own under the State program. I will be covered by my spouse's Family membership.
I understand that I will not have coverage if my spouse loses eligibility unless I apply within 60 days of the mid-year qualifying event.

Signature:____________________________ Date:__________ Social Security #:____________________

***Spouse NOT paying premium must also complete a separate Waiver Form if currently enrolled in the UVA Health Plan to terminate that coverage.**

If you are employed by a state agency other than UVA, have your Benefits Administrator complete the following statement:

I certify that the employee has been continuously eligible for the State Health Benefits Program since (date)____________________

Benefits Administrator's Signature:______________________________ Phone #:____________________

Name of Agency:______________________________________ Date: ____________________

If you are employed by UVA, the Benefits Division will complete the prior statement.

8. HEALTH PROGRAM	❑ High Premium	❑ Low Premium

9. APPLICANT INFORMATION

Last Name	First	Middle Initial	Social Security Number

Street Address	City	State	Zip Code

Home Phone Number	Work Phone Number	Marital Status	Messenger Mail and Email Addresses
( )	( )	❑Single ❑ Married	

10. APPLICANT/SPOUSE/DEPENDENT DATA

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 ❑ Step child* ❑ Other**	Last, First, Middle Initial	Sex ❑ F ❑ M		
	Social Security Number	Mo.	Day	Year
❑ Child ❑ Step child* ❑ Other**	Last, First, Middle Initial	Sex ❑ F ❑ M		
	Social Security Number	Mo.	Day	Year
❑ Child ❑ Step child* ❑ Other**	Last, First, Middle Initial	Sex ❑ F ❑ M		
	Social Security Number	Mo.	Day	Year
❑ Child ❑ Step child* ❑ Other**	Last, First, Middle Initial	Sex ❑ F ❑ M		
	Social Security Number	Mo.	Day	Year
❑ Child ❑ Step child* ❑ Other**	Last, First, Middle Initial	Sex ❑ F ❑ M		
	Social Security Number	Mo.	Day	Year

* I confirm that my stepchild(ren) live(s) with me full time in a regular parent-child relationship, and is (are) eligible to be declared as a dependent(s) on my Federal Tax returns.

Applicant Signature____

** “Other” and handicapped children over the age of 23 must provide documents and be approved for enrollment **prior** to entry into the UVA Health Plan. Contact the Office of University Benefits to learn eligibility and documentation requirements.

11. OTHER COVERAGE

Will you or any listed dependent(s) be covered by any other group health insurance plan or Medicare while enrolled in the UVA Health Plan? ❑ Yes ❑ No

If yes, complete the following: Is the other coverage ❑ Single ❑ Dual ❑ Family

(continued on page 4)

11. OTHER COVERAGE (continued from page 3)

Name(s) of those covered by other plan		
Policyholder's Name	Policyholder's ID Number	Carrier Name

Carrier Phone Number	Carrier Address	Coverage Dates

If covered by Medicare: Name of Policyholder	Disabled ❑ Yes ❑ No	Medicare Number	Part A Effective Date	Part B Effective Date

12. OUT-OF-AREA STATUS FOR ENROLLMENT IN NATIONAL NETWORK

OUT-OF-AREA STATUS IS AVAILABLE UNTIL SUCH TIME THERE ARE SUFFICIENT NUMBER OF NETWORK PROVIDERS NEAR YOUR HOME. IF YOU THINK YOU MAY BE ELIGIBLE FOR OUT-OF-AREA STATUS AFTER LOOKING AT THE PROVIDER DIRECTORY, COMPLETE THIS SECTION. Once completed, this status must be approved by UVA to assure accurate claims payment when you or an eligible dependent resides outside of the service area and is enrolled in the National Network.

Please check one and complete the appropriate information below:

- ❑ Dependent is enrolled in college outside the service area.
- ❑ Child(ren) live with another parent outside the service area.
- ❑ Employee and/or dependents live outside the service area.

Employee's Signature_______________________________ Date:_______________________

List employee and/or dependents who are out-of-area

Name	Date Returning to Area	Daytime Phone Number
Street	City	State Zip Code
Name	Date Returning to Area	Daytime Phone Number
Street	City	State Zip Code
Name	Date Returning to Area	Daytime Phone Number
Street	City	State Zip Code

For Employer/ Group use only: OOA or National Network Exception?

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

I apply for the UVA Health 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 and any reimbursements for claims paid by the plan for an ineligible dependent on my policy. I also authorize any licensed physician, 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. However, I understand that, effective April 14, 2003, 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, 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. 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 for Submitting Application:

- ❑ New Hire
- ❑ Open Enrollment
- ❑ Mid-Year Qualifying Event

Effective Date Of Coverage:	Group No.:	Employer Signature
Oracle or Peoplesoft ID:	Cobra Eligible?	Date: