VIVA HEALTH

Small Business (2-50 employees)
Employee Enrollment Form

417 20th Avenue North
Suite 1100
Birmingham, AL 35203
(205) 558-7474

ENROLLMENT INFORMAION			
REASON FOR ENROLLMENT: ☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Other			
COVERAGE SELECTED: ☐ Health ☐ Waiver of Coverage			
STATUS CHANGE: ☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination ☐ Electing COBRA (Reason for Election) _____ ☐ Waiver of Coverage ☐ Other _____			
OFFICE USE ONLY			
Effective Date		**Processor**	**Date**

PART A	PERSONAL INFORMATION			
Employee's Full Name	**Company Name**		**Occupation**	
Home Address	**City**	**State**	**Zip Code**	**County**
Home Phone	**Work Phone**	**Date of Hire**	**Hours Worked Per Week**	
Sex: ☐Male ☐Female	**Date of birth: (mm/dd/yyyy)**	**Social Security number**: __ __ __ - __ __ - __ __ __ __		
Type of Coverage: ☐ SINGLE ☐ FAMILY	**Are you a U.S. citizen or U.S. National?** ☐ Yes ☐ No	**Primary Language:** ☐ ENGLISH ☐ SPANISH ☐ FRENCH ☐ OTHER _____		

PART B **DEPENDENTS TO BE COVERED**

Individuals listed below may include those eligible according to the Certificate of Coverage. Additional information may be required if Spouse and/or children do not have the same last name as the employee (i.e., birth or marriage certificate).

*If your dependent does not reside with you or is 19 years or older and a full-time student in an accredited institution, please list their present address on a separate sheet of paper. Coverage will not be offered to dependents living outside the service area unless they are full-time students. If you are subject to a court decree to provide health coverage for any dependent(s) listed above, please provide a copy of the decree.

Name of Person to be Covered First MI Last	SS #	Sex	Date of Birth	Is Person a U.S. citizen or U.S. National
Spouse *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		☐ Yes ☐ No
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		☐ Yes ☐ No
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		☐ Yes ☐ No
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		☐ Yes ☐ No
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		☐ Yes ☐ No
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F		☐ Yes ☐ No

Do you or any of your dependents smoke or use tobacco products? ☐ Yes ☐ No

(If yes, please indicate how many times on average per week for the last six months)

PART C **OTHER HEALTH INSURANCE INFORMATION**

Are you presently covered on a health insurance plan? ☐ Yes ☐ No **If yes**, how long has this coverage been continuous? _____

If yes, what type of coverage: ☐ Spouse's Coverage ☐ COBRA ☐ Present Employer's Coverage ☐ Medicare/Medicaid ☐ Other _____

Name of Present Insurance Company: _____ Name of Policy Holder: _____

Policy # or Medicare #: _____ Address of Insurance Company: _____

After coverage becomes effective with VIVA Health, Inc. are you or any family members to be covered by another medical insurance or Medicare?
☐ Yes ☐ No

PART D — WAIVER OF COVERAGE

(TO BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY AN ELIGIBLE EMPLOYEE)

I HAVE ELECTED TO DECLINE COVERAGE FOR THE FOLLOWING REASON:

( ) I am covered under my spouse's health insurance plan Name of Carrier _____

( ) I am covered under other health insurance plan Name of Carrier _____

( ) I am not covered under an insurance plan, but I have elected to refuse coverage at this time.

This is to acknowledge that the available coverages have been explained to me by my employer. I have been given the opportunity to apply for the available coverages and have elected not to enroll myself and/or dependents, if any, as indicated on this application. I understand by waiving coverage that I may not apply for coverage on the employer group plan until open enrollment.

EMPLOYEE SIGNATURE TO WAIVE COVERAGE X_____ **DATE** _____

PART E — MEMBERSHIP CONDITIONS

By signing below I confirm that I am aware of and accept the following VIVA Health, Inc. membership conditions for myself and my dependents, if any: 1) All of my (our) statements on this application are complete and accurate. I (We) understand that any misrepresentations, fraudulent statements, omissions, or incorrect statements in this application may result in rescission of the policy, termination of coverage, increase in premium retroactive to the effective date and other consequences. 2) I (We) understand that any change in the information reported herein arising prior to the effective date of coverage must be reported to VIVA Health, Inc. immediately. 3) I authorize my employer to deduct premiums for coverage from my paycheck and to act as my agent in dealing with VIVA Health, Inc. 4) I (We) authorize any health care provider or entity to release medical information and records pertaining to my (our) medical history and services to VIVA Health, Inc. for any administrative purpose, including claims review, as well as for any analytical or research purpose. 5) I (We) will abide by the applicable Group Health Policy and Certificate of Coverage. 6) I (We) understand that coverage will become effective on the date specified by VIVA Health, Inc. and only after approval of this application and full payment of the first month's premium. 7) I (We) authorize the use of Social Security Number for identification purposes. 8) Pediatric dental coverage is a required essential health benefit mandated by the Affordable Care Act. By signing this application for medical coverage from VIVA Health, you are also agreeing to purchase pediatric (children up to age 19) dental coverage. VIVA Health has entered into an agreement with Delta Dental Insurance Company to provide the required coverage under the Delta Dental Plan 70 for Children. Although this is a separate policy, monthly dental premiums are included in your VIVA Health rates and will be remitted by VIVA Health on your behalf to Delta Dental as part of your monthly premiums to VIVA Health.

X_____		X_____	
EMPLOYEE SIGNATURE	**DATE**	**SPOUSE SIGNATURE**	**DATE**