VIVA HEALTH

EMPLOYEE ENROLLMENT FORM

Access Plan for 51-99 employees

ENROLLMENT INFORMAION

REASON FOR ENROLLMENT:
☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Other

STATUS CHANGE:
☐ Add Dependent ☐ Delete Dependent ☐ Address Change ☐ Termination
☐ Electing COBRA (Reason for Election) _____
☐ Waiver of Coverage ☐ PCP Selection/Change ☐ Other _____
For office use only: Effective Date _____ *Group #* _____

PART A — PERSONAL INFORMATION

Employee's Full Name	Company Name		Position/title	
Home Address	City	State	Zip Code	County

Home Phone	Work Phone	Date of Hire	Hours Worked Per Week
E-mail address	Type of Coverage ☐ Single ☐ Family	Preferred Language if other than English	

PART B — PERSONS TO BE COVERED

Individuals listed below may include those eligible according to the Certificate of Coverage. Additional information may be required if: A) dependent children are over the age 19 (i.e., proof of student status or handicap); B) spouse and/or children do not have the same last name as the employee (i.e., birth or marriage certificate)

Name of Person to be Covered Last First MI	Social Security #	Sex	Date of Birth	Height	Weight
EMPLOYEE		☐ M ☐ F			
Spouse *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F			
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F			
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F			
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F			
Child *Resides with Employee ☐ Yes ☐ No		☐ M ☐ F			

*If your dependent does not reside with you or is 19 years or older and a full-time student in an accredited educational institution, please list the school they are attending and 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.

PART C — OTHER HEALTH INSURANCE INFORMATION

After coverage becomes effective with VIVA Health, will you or any dependents listed above be covered by any other medical insurance or health plan including Medicare or another VIVA Health plan? ☐ YES (COMPLETE THE INFORMATION BELOW) ☐ NO (SKIP TO PART D)

If yes, what type of coverage: ☐ Spouse's Employer ☐ COBRA ☐ Medicare ☐ Medicaid ☐ Other (describe): _____

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

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

Which family members listed in Part B are covered by this plan?: _____

If you or any of your dependents are enrolled in Medicare, please attach a copy of the Medicare ID card(s). If you or your dependents have more than one other coverage, please attach a sheet with the same information requested in this section on the additional coverage(s) to this application.

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 ☐ dental insurance plan Name of Carrier _____

( ) I am covered under other ☐ health ☐ dental 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 coverage has been explained to me by my employer. I have been given the opportunity to apply for the coverage and have elected not to enroll. I understand by waiving coverage that I may not apply for coverage for myself or my dependents until open enrollment or a qualifying life event and may be subject to pre-existing condition exclusions for my dependents and myself.

EMPLOYEE SIGNATURE TO WAIVE COVERAGE X _____ DATE _____

PART E — MEDICAL INFORMATION

You must complete this section honestly and completely for each person listed in section B above. Your coverage may be terminated or non-renewed or your premiums may be adjusted upward retroactively to your effective date if you leave out or misrepresent information.

In the last 3 years have you or any of your dependents listed in Part B of this application been diagnosed with or treated for any serious condition or illness? Serious conditions include but are not limited to the following: cancer, diabetes, multiple sclerosis, HIV/AIDS, congenital birth defects, transplants, hemophilia, diseases of the liver, kidney, lungs, heart/circulatory system or mental/nervous disorders? ☐ Yes ☐ No

In the last 3 years have you or any of your dependents listed in Part B of this application had surgery or been hospitalized? ☐ Yes ☐ No

Are you or any of your dependents listed in Part B of this application currently receiving treatment for a chronic or ongoing medical condition? ☐ Yes ☐ No

Are you or any of your dependents listed in Part B currently pregnant? ☐ Yes ☐ No If you answered "Yes", is there a history of the pregnant individual having pre-term labor or a premature birth? ☐ Yes ☐ No

If you answered YES to any of the questions listed above, please use the space below to explain. Attach a separate sheet of paper if more space is required.

NAME OF PERSON	CONDITION/ DIAGNOSIS	TYPE OF TREATMENT and MEDICATIONS	DATES TREATED	PROGNOSIS/DEGREE OF RECOVERY	PHYSICIAN'S NAME, ADDRESS & PHONE NO.

PART F — MEMBERSHIP CONDITIONS

By signing below I confirm that I am aware of and accept the following VIVA Health 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 omissions or incorrect statements in this application may invalidate coverage retroactively. 2) I (We) understand that any change in the health information reported herein arising prior to the effective date of coverage must be reported to VIVA Health 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. 4) I (We) authorize any health care provider or entity, pharmacy benefits manager, insurer/reinsurer, or claims clearinghouse and any of their business associates to release medical information and records pertaining to my (our) medical history and services to VIVA Health for treatment, payment and health care operations including any administrative purpose such as application evaluation and claims review. 5) I (We) authorize VIVA Health and its business associates to obtain, use, and disclose my medical, claim or benefit information as needed for payment, treatment, and health care operations and as otherwise allowed/required by law. 6) I (We) will abide by the applicable Group Health Policy and Certificate of Coverage. 7) I (We) understand that coverage will become effective on the date specified by VIVA Health and only after approval of this application and full payment of the first month's premium. 8) I (We) authorize the use of Social Security Number for identification purposes. My (our) signature on this application means that I have read and understood the contents of this application.

X _____ X _____

EMPLOYEE SIGNATURE DATE SPOUSE SIGNATURE (IF LISTED IN SECTION B) DATE

This form may contain personal health information and is to be completed in confidence by the employee. Completed forms should be placed in a sealed envelope and returned to your Human Resources Department.