VIVA HEALTH

ACCESS ENROLLMENT/STATUS CHANGE FORM

☐ New Enrollment ☐ Re-Enrollment ☐ Change Infromation ☐ Request Termination

Show Reason For Change:

☐ Marriage ☐ COBRA ☐ Open Enrollment
☐ Birth/Adoption ☐ Employment Terminated ☐ Name Change
☐ Moved Out-of-Area ☐ Not An Eligible Employee ☐ Family to Single
☐ Address Change ☐ Not an Eligible Dependent ☐ Single to Family

Primary Language
☐ English ☐ Spanish ☐ Other

Employee (Last, First, Middle Initial)				Hire Date
Home Address	Apt. Number	City	State	Zip Code
Home Telephone Number / Work Telephone Number	Employer			

DEPENDENTS 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 Number	Sex	Date of Birth
Employee		☐ M ☐ F	
SPOUSE		☐ M ☐ F	
Child		☐ M ☐ F	
Child		☐ M ☐ F	
Child		☐ M ☐ F	
Child		☐ 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.

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

EMPLOYEE AUTHORIZATION

I have read and agreed to the authorization on the reverse side of this form.	Employee Signature _____	Date _____

EMPLOYER VERIFICATION

Employer Signature _____	Group Number	Employment Date	Effective Date