THE UNIVERSITY OF ALABAMA
AT BIRMINGHAM
MEDICAL CENTER STUDENT HEALTH

Please mail to: Student Health Service
930 20th Street South
Suite 221
Birmingham, AL 35294-2042

APPLICATION FOR VIVA HEALTH
MANDATORY STUDENT HEALTH PLAN

(Do not complete this form if you desire Optional/Undergraduate Student Insurance or if you are signing a waiver. This is to be completed only if you are enrolled in one of the schools listed below that mandates health insurance.)

DATE: _____/_____/_____

Student's ID #	**Social Security #:**	**Telephone #:**	**E-mail Address:**
Student's Last (Family) Name:		**Student's First Name:**	**Middle Initial:**
Sex: ☐ **Male** ☐ **Female**		**Birth Date:** / /	
Street Address:			
City:		**State:**	**Zip Code:**
Semester: ☐ Fall Semester ☐ Spring Semester ☐ Summer Semester ☐ Other _____			
School or College in which you are enrolling (Check one): ☐ Medical ☐ Dental ☐ Optometry ☐ Nursing ☐ Health Related Professions ☐ Public Health ☐ Graduate (Degree Seeking) ☐ International Student ☐ International Scholar			
Coverage Desired: ☐ Student Only ☐ Student & Spouse ☐ Student, Spouse & Child(ren)			

Please be sure to choose a Personal Care Provider for any spouse or children added to the plan.

RELATIONSHIP (CHECK ONE):	SEX	FULL NAME LAST (FAMILY) FIRST MI	BIRTH DATE	PERSONAL CARE PROVIDER (PCP)
SPOUSE	☐ Male ☐ Female		/ /	
CHILD	☐ Male ☐ Female		/ /	
CHILD	☐ Male ☐ Female		/ /	
CHILD	☐ Male ☐ Female		/ /	
CHILD	☐ Male ☐ Female		/ /	

I desire coverage by VIVA HEALTH Student Health Plan to become effective when I am officially enrolled. I understand that my insurance will remain active for the entire UAB academic school year. I understand that it will be **Automatically Renewed** at the beginning of the next UAB academic year if I remain eligible. I will be responsible for payment of premiums. I will notify Student Health Services when I am no longer a student. I (we) authorize the release and use of all my (our) medical records or information necessary to process claims or in any way determine benefits due. Medical information can also be used to execute the obligations imposed on VIVA HEALTH, Inc. by state or federal statutes, as well as for the Quality Assurance or Peer Review programs conducted by VIVA HEALTH, Inc. or its designated agents.

STUDENT SIGNATURE: _____ **DATE:** _____

EFFECTIVE DATE: _____
MEMBER NUMBER: _____

For Office Use Only

DATE	CHARGE	CODED	DATE	CHARGE	CODED