UNIVERSITY OF VIRGINIA HEALTH PLAN, DENTAL PLAN AND DAVIS VISION ENROLLMENT APPLICATION

1. EMPLOYMENT STATUS

☐ Active Employee ☐ Postdoctoral Fellow (non-UVA Employee) ☐ Housestaff

2. REASON APPLICATION IS BEING SUBMITTED; DOCUMENTATION VERIFYING DEPENDENT ELIGIBILITY IS REQUIRED

☐ New Hire: Date of Employment _____ ☐ Open Enrollment Period _____

☐ Qualified Life Event Date of Qualified Life Event _____

Additions **(Appropriate documentation required. Please attach)**

- ☐ Birth/adoption of child
- ☐ Marriage
- ☐ Termination of employment by the employee's spouse/child
- ☐ Department of Social Services Health Care Coverage Order
- ☐ Other (Please list qualified life event): _____

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

- ☐ Divorce
- ☐ Commencement of employment by the employee's spouse/child
- ☐ Department of Social Services Health Care Coverage Order
- ☐ Death of spouse or child
- ☐ Other (please list qualified life event): _____

3. APPLICANT INFORMATION

First Name	Middle Initial	Last Name	
Street Address	City	State	Zip
Phone	UVA Computing ID		

4. ENROLL/WAIVE: HEALTH, DENTAL, VISION

UVA HEALTH PLAN

- Those on a J1 Visa must elect J Visa Health Plan
- Postdoc fellows (non-UVA employees) are not eligible for Basic Health
- Housestaff are not eligible for Basic Health

☐ **WAIVE:** I am not enrolling in a health plan and understand I can only during open enrollment or a qualified life event (if waiving, skip to the next plan)

Enroll	Type of Membership
☐ Basic Health with Health Savings Account	☐ Participant Only
☐ Value Health	☐ Participant + Spouse
☐ Choice Health	☐ Participant + Child(ren)
☐ J Visa Health (J1 Visa holders only)	☐ Family (Participant, Spouse, and Child/children)

UVA DENTAL PLAN

- Postdoc fellows (non-UVA employee) and Housestaff are not eligible for Enhanced Dental

☐ **WAIVE:** I am not enrolling in a dental plan and understand I can only enroll during open enrollment or a qualified life event (if waiving, skip to the next plan)

Enroll	Type of Membership
☐ Basic Dental	☐ Participant Only
☐ Enhanced Dental	☐ Participant + Spouse
	☐ Participant + Child(ren)
	☐ Family (Participant, Spouse, and Child/children)

DAVIS VISION

- Postdoc fellows (non-UVA employee) are not eligible for Davis Vision

☐ **WAIVE:** I am not enrolling in a vision plan and understand I can only during open enrollment or a qualified life event (if waiving, skip to the next section)

Enroll	Type of Membership
☐ Davis Vision	☐ Participant Only
	☐ Participant + Spouse
	☐ Participant + Child(ren)
	☐ Family (Participant, Spouse, and Child/children)

5. HEALTH SAVINGS ACCOUNT (HSA) for Basic Health plan participants only

If you have elected Basic Health, you will be enrolled in a Health Savings Account with Fidelity effective the first of the following month. If you would like to set up your own contributions to your HSA through payroll deduction, enter the annual amount here for this calendar year:

_____ **annual contribution for this calendar year.** View contribution limits.

You are not required to contribute, and you can change your contribution at any time effective the first of the next month.

Contributions will be distributed over the remaining payrolls for this calendar year to reach your annual target.

*Please watch for any emails from Fidelity as they may need additional information to open your account. No contributions can be made until the account is open and ready for funding.

6. FLEXIBLE SPENDING ACCOUNT (FSA)

Please note that not all qualified life events allow enrollment in an FSA. Please see the HR website for more information about FSAs. Once you elect an FSA, you cannot make changes until open enrollment for the following plan year.

☐ I elect a **Healthcare FSA** with Fidelity for a total of _____ for this calendar year (max $2,500, minimum $120).

☐ I elect a **Dependent Daycare FSA** with Fidelity for a total of _____ for this calendar year (max $5,000 per household), can only be used for qualified daycare expenses for eligible dependents; see HR website for eligibility criteria.

7. SPOUSE/DEPENDENT DATA (only if enrolling spouse/dependents in one or more plans)

If applicable, please add your spouse and/or dependent information into Workday so that they are available to add to plans

- In Workday, go to Menu at the top left and choose Benefits & Pay Hub
- Expand benefits menu on the left and choose "Dependents."
- Add
- Enter required information. Enter social security number or ITIN, or reason it is not available, under "National IDs."
- Submit.

Include relationship and name below to confirm who is to be added to each plan.

Relationship	Name	(Check All That Apply)
☐ Spouse	Last, First, Middle Initial	☐ Health Plan ☐ Dental Plan ☐ Davis Vision
☐ Child ☐ Disabled Child * ☐ Other **	Last, First, Middle Initial	☐ Health Plan ☐ Dental Plan ☐ Davis Vision
☐ Child ☐ Disabled Child* ☐ Other **	Last, First, Middle Initial	☐ Health Plan ☐ Dental Plan ☐ Davis Vision
☐ Child ☐ Disabled Child * ☐ Other **	Last, First, Middle Initial	☐ Health Plan ☐ Dental Plan ☐ Davis Vision

* Disabled children over the age of 26 must provide documents and be approved for enrollment **prior** to entry into the UVA Health Plan, Dental Plan, and Davis Vision. Contact the UVA HR Solution Center to learn eligibility and documentation requirements.

** I confirm that I am the legal guardian with a court order to assume permanent custody of the "Other" child(ren) who live(s) with me full-time in a regular parent-child relationship and is (are) claimed on my Federal Tax returns.

Applicant Signature: _____

8. *APPLICANT SIGNATURE (*Required. Review information and sign below to accept)

General Signature Information:

AUTHORIZATION: I authorize deductions from my earnings for all contributions to any Group or Voluntary Plans and programs I elect during an enrollment process. Once my elections are confirmed, it is my responsibility to review the elections and immediately contact UVA HR if any of the elections are different from those I selected so they can be corrected.

PLAN DETAILS: I understand all Plan and program information is available on the **UVA HR** website. I also understand communication for Plan and/or program operations will be delivered via email when an email address is on file, or through the postal address listed in the payroll system when no email is on file. I consent to email notification of Plan and/or program operations. I agree to comply with the terms and conditions of all Plans or programs in which I am enrolled.

If you have elected Health, Dental, and/or Vision:

Section 125: Enrollments in pre-tax plans can only be made during new hire or qualified life event eligibility periods, or open enrollment. **Once my elections are confirmed, it is my responsibility to review the PDF Confirmation Statement at the end of my enrollment and immediately contact UVA HR if any of the elections are different from the ones I chose so they can be corrected.** I may not change my enrollments following my submission. Dependent documentation is required for newly added dependents, and Social Security Numbers (or Tax ID #) are required for all family members covered under Group Voluntary Plans. I understand appropriate supporting documentation is required to enroll my eligible dependents. Required Documentation must be attached in the Attachments section box.

HIPAA PRIVACY NOTICE

I apply for the UVA Health Plan, UVA Dental Plan, and/or Davis Vision 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, including reimbursement to

the health and dental plans for ineligible claims paid on behalf of ineligible or eligible family members enrolled on my policy, and reimbursement to the Health Savings Account Program for duplicate or inaccurate employer contributions. I also authorize any licensed physician, dentist, 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. In addition, I authorize the UVA Health Plan, UVA Dental Plan, and/or Davis Vision Plan and any other organization, institution, or person acting on the plan's behalf, to audit me and my family members' enrollment eligibility. I understand that 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, dentist 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, including follow-up health education, disease management, and improvement of the UVA Health Plan and its Hoo's Well program. 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. Any false statements I have provided shall be considered grounds for disciplinary action and other possible penalties for insurance fraud.

If you are adding your spouse as a dependent on your health plan election, signing below verifies that your spouse is either:

NOT eligible for affordable Health Benefits from his/her employer that provides minimum value, as defined by the Affordable Care Act; OR
Eligible for Affordable Health Benefits from his/her employer that provides minimum value, as defined by the Affordable Care Act, but ALL of his/her employer's health options are HMOs and the spouse lives outside the HMOs' defined service areas.

PLEASE CLICK HERE TO REVIEW THE SPOUSAL AFFIDAVIT

If you have enrolled in a Flexible Spending Account (FSA):

I hereby authorize my employer to deduct from my salary (if applicable), or other compensation, the required contributions for the amounts I have selected above, including reimbursement for any ineligible expenses. I agree to comply with the terms and conditions of the plan. I have received and read all the authorizations and acknowledgements provided by Fidelity for each plan elected on the previous page of this form. I also acknowledge the receipt of the **UVA HIPAA PRIVACY NOTICE** as well as the **FIDELITY PRIVACY NOTICE**. Any reimbursements I receive from Fidelity must be deposited directly into my personal checking or savings account.

I understand that:

- I am enrolling in a qualified plan and a description of the plan has been made available to me. I must use the funds I have elected to set aside in my reimbursement account(s) by the end of the Grace Period (2 1/2 months after the end of the Plan Year) and submit my claims no later than 46 days after the end of the Grace Period or the funds will be forfeited. If I terminate my enrollment in the qualified plan during the calendar year, I must use the funds by the end of the month in which I terminate enrollment or employment.
- I cannot change my mind once the Plan Year begins; my elections must remain in effect for the duration of the Plan Year unless I have a change in family status (marriage, divorce, birth, adoption, or death) or in employment status.
- My out-of-pocket expenses must be incurred while I am an eligible participant and during the Plan Year or its Grace Period to be considered for reimbursement (the date of service, not the date of the invoice, must occur during the Plan Year or its Grace Period). If I terminate my enrollment or employment during the Plan Year, expenses must be incurred before the end of the month in which I terminate my enrollment or employment.
- I cannot itemize and deduct my out-of-pocket expenses on my IRS form 1040 for any accounts in which I am enrolled (premiums, health and/or daycare).
- I understand that I am required to save all receipts for benefit card purchases in case I should be audited by the IRS through Fidelity.

If you have enrolled in a Health Savings Account (HSA):

By signing below, you are acknowledging reading, and agreeing to, the HSA Terms and Conditions document and the actions needed by the vendor to create your HSA account. If you cannot agree to this statement, please contact the Solution Center at AskHR@virginia.edu or call 434-243-3344.
PLEASE CLICK HERE TO REVIEW FIDELITY'S HSA TERMS AND CONDITIONS
I acknowledge that the Fidelity HSA is governed by a pre-dispute arbitration clause, which appears on the last page of the HSA Brokerage Customer Agreement in the Fidelity HSA Documents accessible above, and which I represent having read and agreed to.

Applicant Signature _____ **Date** _____

Options to submit completed form and documentation:

- Email form and scanned/photographed documentation to askhr@virginia.edu (do not email sensitive data)
- Upload directly into Workday (enter "maintain my worker documents" into the Workday main search bar); you must notify askhr@virginia.edu that you have uploaded documents
- Fax to: (434) 924-4486

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