univera HEALTHCARE

Student Medical Leave Form
Employer Group

Instructions for the Subscriber:

- ☐ Please apply for coverage if your dependent enrolled under student coverage needs a medically necessary leave of absence.
- ☐ Subscriber complete Section 1 and sign
- ☐ Forward Section 2 to dependent's doctor
- ☐ Once all pages are complete and returned to you, mail the entire original form to: P.O. Box 211256, Eagan, MN 55121
- ☐ Send a copy of the form to your employer

The following information is required to determine whether your dependent is eligible for a medically necessary leave of absence.

Section 1: Subscriber and Dependent Information (Completed by Subscriber)		
Subscriber Last Name:	Subscriber First Name:	MI:
Subscriber ID:	Group Number:	
Dependent's Last Name:	Dependent's First Name:	MI:
Is Dependent presently married? Yes No	Dependent's Date of Birth:	
Name of school dependent is/was attending:		
Address of school student is/was attending:		
Is the student an "Away from Home Care" member? Yes No		

I request coverage under my policy for my student dependent named on this form. I understand that their enrollment may be continued only as long as they are unmarried. I also understand that I'll inform Univera Healthcare of any changes in the status of my dependent's medical leave or eligibility for coverage (for example, marriage).

Upon approval of a medically necessary leave of absence, students may continue to be covered as an active dependent on their parent's policy (or as an active sponsored student enrolled in their own name) for up to six months from the first date of absence or until they reach the maximum age as defined in the contract.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature:	Date:

B-3021
05/20

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Instructions for the Physician:

This form is to determine whether your patient is eligible to continue student coverage due to a medically necessary leave of absence. Thank you in advance for your prompt and thorough attention to this form on behalf of your patient as it is critical for the determination.

- ☐ Complete and sign Section 2
- ☐ Attach any applicable documentation to support status (i.e. clinical summary)
- ☐ Return the original to the subscriber

Section 2: Medical Information - Completed by Attending Provider (MD, DO, NP or PA)

Physician's Last Name:	First Name:	
Physician's Address:		
City:	State:	Zip:
Phone Number: ( ) -	Onset Date of Illness/Injury:	
Patient's symptoms result from: Illness Injury Other:		
In your medical opinion is the student too ill to return home? Yes No		
It is my recommendation, based on medical necessity, that the medical leave period being applied for begin on_____. The anticipated end date of the Medical Leave period is_____.		
I certify that this patient is presently under my care and that I see this patient on a regular ongoing basis. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.**		
Name of Physician (please print):		
Physician's Signature:	Date:	