Carnegie Mellon University

2014 Benefits Enrollment/Change Form for COBRA Participants

Read the Benefits Workbook for COBRA Participants and Summary of Benefits and Coverage for each plan, available at www.cmu.edu/hr/benefits/OE/index.html, for more information about benefit plan options, costs and requirements.

COBRA Participant Information — Please print or type.

Last Name	First Name	M.I.	Social Security Number

Street Address	Sex: ❑ M ❑F	Date of Birth - Month/Day/Year

City	State	Zip	Work Phone	Home Phone

BENEFITS EFFECTIVE DATE: 01/01/2014

Medical Election

I elect the following medical carrier:

- ❑ UPMC
- ❑ HealthAmerica
- ❑ Highmark
- ❑ Cigna Expatriate International
- ❑ Waive medical/prescription coverage

NOTE: If you elect medical coverage, you must select a prescription option for the same individuals.

I elect the following medical plan:

- ❑ PPO Option 1 (Highmark/UPMC)
- ❑ PPO Option 2 (Highmark/UPMC)
- ❑ PPO Option 3 (Highmark/UPMC)
- ❑ High Deductible PPO w/HRA (Highmark/UPMC)
- ❑ HealthAmerica HMO
- ❑ Comprehensive (Highmark only)
- ❑ Cigna Expatriate International

I elect the following level of coverage:

- ❑ Individual
- ❑ Individual & Child
- ❑ Individual & Children
- ❑ Individual & Spouse
- ❑ Individual & Domestic Partner
- ❑ Family (individual, spouse, children)
- ❑ Family (individual, DP, children)

Dental Election

I elect the following dental plan:

- ❑ UCCI PPO Option 1
- ❑ UCCI PPO Option 2
- ❑ UCCI DHMO
- ❑ Cigna Expatriate International
- ❑ Waive dental coverage

I elect the following level of coverage:

- ❑ Individual
- ❑ Family (employee, spouse, children)
- ❑ Family (employee, DP, children)

Prescription Election

I elect the following prescription drug plan:

- ❑ Caremark Option A
- ❑ Caremark Option B
- ❑ Cigna Expatriate International
- ❑ Waive medical/prescription coverage

Vision Election

I elect the following vision plan:

- ❑ Davis Vision Option 1
- ❑ VBA Option 1
- ❑ Davis Vision Option 2
- ❑ VBA Option 2
- ❑ Cigna Expatriate International
- ❑ Waive vision coverage

I elect the following level of coverage:

- ❑ Individual
- ❑ Family (employee, spouse, children)
- ❑ Family (employee, DP, children)

Additional Medical Coverage

Complete if you or any of your dependents are covered by medical insurance in addition to the Carnegie Mellon plan.

Insurance Company	Group Number	ID Number

Additional information required on reverse side.

Employee & Dependent Information

Complete if covering spouse/domestic partner or children. Copy this page if needed for additional dependents.

COBRA Participant	**If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required:** ❑ Check here if currently a patient of PCP				**If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required:** ❑ Check here if currently a patient of PCD	
❑ **Spouse** ❑ **Domestic Partner**	Last Name	First Name	MI	Sex ❑ M ❑ F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: **Add to:** ❑ Medical ❑ Dental ❑ Vision **Delete from:** ❑ Medical ❑ Dental ❑ Vision	**If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required:** ❑ Check here if currently a patient of PCP				**If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required:** ❑ Check here if currently a patient of PCD	
Dependent 1	Last Name	First Name	MI	Sex ❑ M ❑ F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: **Add to:** ❑ Medical ❑ Dental ❑ Vision **Delete from:** ❑ Medical ❑ Dental ❑ Vision	**If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required:** ❑ Check if currently a patient of PCP				**If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required:** ❑ Check if currently a patient of PCD	
Dependent 2	Last Name	First Name	MI	Sex ❑ M ❑ F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: **Add to:** ❑ Medical ❑ Dental ❑ Vision **Delete from:** ❑ Medical ❑ Dental ❑ Vision	**If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required:** ❑ Check if currently a patient of PCP				**If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required:** ❑ Check if currently a patient of PCD	
Dependent 3	Last Name	First Name	MI	Sex ❑ M ❑ F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: **Add to:** ❑ Medical ❑ Dental ❑ Vision **Delete from:** ❑ Medical ❑ Dental ❑ Vision	**If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required:** ❑ Check if currently a patient of PCP				**If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required:** ❑ Check if currently a patient of PCD	
Dependent 4	Last Name	First Name	MI	Sex ❑ M ❑ F	Social Security Number	Date of Birth (Month/Day/Year)
Activity: **Add to:** ❑ Medical ❑ Dental ❑ Vision **Delete from:** ❑ Medical ❑ Dental ❑ Vision	**If electing an HMO for your medical care, Primary Care Physician Practice Code (not name) required:** ❑ Check if currently a patient of PCP				**If electing the DHMO for your dental care, Primary Care Dentist Practice Code (not name) required:** ❑ Check if currently a patient of PCD	

COBRA Participant Signature

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 subject such person to criminal and civil penalties. I agree to comply with all provisions and procedures that govern administration of the Benefit Plans for Carnegie Mellon. I understand the university will make the necessary adjustment to my costs based on these changes/elections.

_____ _____

Signature Date

Return by Monday, November 25th to:

Benefit Coordinators Corporation (BCC)
Two Robinson Plaza, Suite 200
Pittsburgh, PA 15205

Questions? *Contact BCC at 800-685-6100*