UPMC Health Plan

Member Application & Change Form

Instructions: This application allows you to enroll in a UPMC Health Plan product, or to make certain changes if you are already a member. Read the instructions and carefully fill out the form. Please write clearly.

❶ Select a Plan
You must choose from the plans that are offered by your employer. You may select only one type of medical plan.

❷ Reason for Application
Choose Open Enrollment if you are joining the Health Plan during your company's annual open enrollment period. Check another option, if appropriate.

❸ Change of Status/Coverage
These sections are for existing UPMC Health Plan members who are making routine changes involving their dependents or demographic information.

❹ Type of Coverage
Tell us who will be covered under your selected plan. Then choose the medical, UPMC Dental *Advantage*, and/or UPMC Vision *Advantage* coverage option. Fill this out carefully as it may affect the amount you contribute toward your benefits each pay period.

❺ Employee Information
This section asks for basic information about you. Your company's human resources department can tell you your first day of employment, if you do not remember.

❻ Covered Family Members
List full name, coverage option, Social Security number, sex, date of birth, and email address for yourself and each dependent you wish to cover under your UPMC Health Plan benefits. If you have more than three dependents, use an additional form. If any of your dependents are disabled, complete and attach a Disabled Dependent Certification Form.

Call Member Services at 1-888-876-2756 or visit **www.upmchealthplan.com** to obtain the form. If you are enrolling in our HMO, we require that you look up your primary care provider's (PCP) name and practice number in our provider directory and enter that information for yourself and each of your dependents. If you have selected a plan other than an HMO, you are not required to select a PCP and can leave the PCP section blank.

❼ Other Group Health Insurance
If you or any dependents who are enrolling have other health insurance — including Medicare, dental, or vision coverage — list the person's name and information about the other health insurer. Attach a separate sheet if necessary.

❽ Signature
Please remember to sign and date the form. Retain a copy for your records.

On this application, references to "Dental" and "Vision" refer to UPMC Dental *Advantage* and UPMC Vision *Advantage* respectively. If you have any questions about this application, please contact your employer.

Employee Name
(First, MI, Last): _____

For employer use only:

Group #: _____ Effective date: _____

Sub-group #: _____

Plan selection: ☐ Medical ☐ Dental ☐ Vision

1 Select a Plan

☐ HMO ☐ PPO

☐ EPO ☐ PPO Out of Area

☐ POS

Consumer *Advantage*

☐ HRA (CDHP)

☐ HSA (CDHP)

UPMC *HealthyU*

☐ HIA ☐ HSA

☐ HRA

UPMC Dental *Advantage*

☐ Basic ☐ Premium

☐ Standard

UPMC Vision *Advantage*

☐ Basic ☐ Premium ☐ Wellness Only

☐ Standard

2 Reason for Application

☐ Open Enrollment ☐ New Hire ☐ COBRA ☐ Mini-COBRA ☐ Qualifying Event ☐ Other

3 Change of Status/Coverage

☐ Select/Change PCP ☐ Add Dependent ☐ Other

☐ Change Address ☐ Drop Dependent ☐ COBRA

☐ Change Name ☐ Birth ☐ Date of Qualifying Event:

Former Name:

_____

☐ Marriage

_____

4 Type of Coverage	Medical	Dental	Vision	Waive
Employee Only	☐	☐	☐	☐
Employee and Spouse	☐	☐	☐	☐
Employee and Child	☐	☐	☐	☐
Employee and Children	☐	☐	☐	☐
Family	☐	☐	☐	☐

Reasons for Waiving Coverage:

- ☐ Covered by spouse's group coverage
- ☐ Enrolled in another insurance carrier's plan
- ☐ Spouse covered by employer's group coverage
- ☐ Medicare
- ☐ Other:

I acknowledge I have been given the right to apply for this coverage; however, I, and/or my dependent(s), am/are electing not to enroll. I acknowledge that I, and/or my dependent(s), may have to wait until the plan's next anniversary date to be enrolled for group coverage. Please sign here only if you are declining coverage for yourself and/or dependent(s):

Name: _____ **Date:** _____

5 Employee Information

Last Name:	First Name:	Middle Initial:
Home Phone:	Work Phone:	
Home Address:		
City:	State:	Zip Code:
Employer Name:	First Day of Employment:	

6 Covered Family Members	Self	Spouse	Dependent	Dependent	Dependent
Name (First, MI, Last)					
Coverage	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision
Social Security #					
Sex	M F	M F	M F	M F	M F
Birth Date (Month/Day/Year)	/ /	/ /	/ /	/ /	/ /
Dependent Code*			FTS DD	FTS DD	FTS DD
Email Address					
PCP**					
Practice #**					
Already a Patient?**					

*FTS = Full-Time Student; DD = Disabled Dependent (certification required)

**This section is only for HMP Members.

7 Other Group Health Insurance

Name of covered member: _____

Name of health insurance company: _____

Policy number: _____

Effective date: _____

8 Signature

Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) of applicable contributions from my wages. I have read and agree with the terms as stated on this application. By acceptance of coverage and upon signing this application, for so long as I am enrolled in UPMC Health Plan I understand, on behalf of myself and my eligible dependents and spouse, if any, that all of my/our health care, dental, and/or vision providers will release to UPMC Health Plan or its authorized agents all information related to my/our medical, dental, and vision history and treatment, including mental health, substance abuse treatment/conditions, and AIDS-related information, if any, for all lawful purposes relating to the administration of my health/dental/vision benefits, including determining or reviewing coverage claims, quality assurance, clinical resource management, and utilization review for services that I/we request or receive. I further understand that UPMC Health Plan will release such information to health care, dental, and/or vision entities for such purposes. My right to revoke this consent in writing at any time will not apply to the extent that UPMC Health Plan or any other provider already has acted in reliance on this statement. The term "UPMC Health Plan" collectively refers to UPMC Health Plan, Inc., UPMC Health Network, Inc., and UPMC Health Benefits, Inc.

I further understand that information will be released by, to, or among the various UPMC Insurance Services Division entities for all lawful purposes, including administration of Workers' Compensation and Short-Term Disability, medical management, and implementation of health/wellness initiatives.

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 subjects such person to criminal and civil penalties. I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

UPMC Health Plan administers benefit plans underwritten by UPMC Health Network, Inc., and UPMC Health Benefits, Inc. This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

Employee Signature: _____ **Date:** _____

Authorized Employer Signature: _____ **Date:** _____

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