UPMC HEALTH PLAN | UPMC HEALTH BENEFITS

MEMBERSHIP TERMINATIONS FOR
MONTH of _____ , 20____

Group Number: _____

Group Name: _____

Please indicate below any changes to your billing address.	
Street Address:	
City, State, Zip:	
Contact Person:	
Contact Phone #:	Contact E-mail:

This form should be used ONLY for employee terminations from your group insurance policy.

To add employees to your insurance plan, or to report employee status changes caused by a qualifying event, please submit a UPMC Health Plan Member Application and Change form.

If you have questions about your invoice, please contact UPMC Health Plan at **1-888-499-6913** and select from the following options:

Group enrollment …… Option 1
Premium billing …… Option 2

Member Name	**Member ID #**	**Date that Coverage Ends**	**Reason for Termination***	**Qualifying Event Code****	**FW SEP (for UPMC use)**
			UPMC S/ENR (for UPMC use)		

* Possible reasons for termination from a group health insurance policy include resignation, dismissal from employment, retirement, death, moving out of the service area, etc.

** Qualifying event codes:

1C: Termination of employment
2C: Reduction of work hours
3C: Medicare
4C: Death
5C: Divorce
7C: Ineligible child
8C: Bankruptcy of retired employee

Completed by: _____ Date: _____

DO NOT RETURN THIS FORM WITH YOUR PAYMENT.

Please return to:
UPMC Health Plan, Suite 500, One Chatham Center, Pittsburgh, PA 15219