

Instruction Sheet

MEMBER APPLICATION AND CHANGE FORM

UPMC HEALTH PLAN
Where you belong.

The attached application form will enable you to enroll in a UPMC Health Plan product or to make certain changes if you are already a member. Please fully read the brief instructions on the form and carefully fill out the sections that apply to you. If you are not clear about what information is requested, refer to detailed instructions below.

1 Selecting a Plan

Your open enrollment kit and/or your employer have provided you with information that describes the benefit plans available to you. Please select the Health Maintenance Organization (HMO), the Exclusive Provider Organization (EPO), the Enhanced Access Point of Service plan (EAPOS), the Preferred Provider Organization (PPO), or the Out of Area plan. If your employer is offering a consumer directed health plan, and you wish to enroll, please select either Consumer Advantage HRA or Consumer Advantage HSA. Your choice must be a plan that is offered by your employer. Please select only one.

2 Applicant Status

Four boxes appear under the heading "Please Check All That Apply." In the Application for Membership box, choose Annual Enrollment if you are joining the Health Plan during your company's annual open enrollment period, or other options as appropriate. The Change of Coverage and Change of Status boxes are for existing UPMC Health Plan members who are making routine changes that involve their dependents or their demographic information. In the Type of Coverage box, tell us the type of coverage you require. Fill this box out carefully as it may relate directly to the amount you contribute toward your benefits each pay period.

3 Employee Information

In this section, we are requesting basic information about you. If you don't remember your date of employment – the first day you worked for your current employer – please ask your human resources department.

4 Covered Family Members

List full name, Social Security number, sex, and date of birth for yourself and for each dependent that you wish to cover under your UPMC Health Plan benefits. Please print clearly. This information will be transcribed by the Health Plan and become part of your health record. 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 index and enter that information. If you have selected a POS, EPO, CDHP or PPO plan, you are not required to select a PCP and can leave the PCP section blank.

5 Other Group Health Insurance

If you or any dependents who are going to be covered by the Health Plan have other health insurance, list the person's name and information about the other health insurer. There are rules that govern which company covers health services, and it is important that we have this information to coordinate your coverage.

6 Signature

Please remember to sign and date the form. Keep the pink copy and follow your employer's instructions about turning in the rest of the form.

MEMBER APPLICATION AND CHANGE FORM							
Please print neatly or type: Select a Plan: <input type="checkbox"/> HMO <input checked="" type="checkbox"/> EAPOS <input type="checkbox"/> PPO <input type="checkbox"/> Out of Area <input type="checkbox"/> Consumer Advantage HRA <input type="checkbox"/> Consumer Advantage HSA				For employer use only: Group #: _____ Sub-Group #: _____ Effective Date: / /		UPMC HEALTH PLAN Where you belong.	
You must select a plan that your employer offers.							
Applicant Status (Please Check All That Apply):							
Application for Membership <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Event		Change of Coverage: <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Date of Qualifying Event		Change of Status: <input type="checkbox"/> Address <input type="checkbox"/> Former Name		Type of Coverage (check one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child <input type="checkbox"/> Employee and Children <input type="checkbox"/> Family	
Employee Information							
Last		First		Middle Initial		Social Security #	Date of Birth
Home Address / Apt. No.		City		State	Zip Code	Home Telephone	
Employer / Company Name				Date of Employment		Work Telephone	
Covered Family Members							
*Please use the provider index to select primary care physicians (PCPs) for yourself and each of your covered dependents.							
Name (First, MI, Last)		Social Security #		Sex	Birth date	Dependent	Name of PCP*
				M F	Mo/Day/Yr	19 or older**	Practice #
						FTS DD	Already a Patient?
							Required only for HMO members
Self				<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/> Yes
Spouse				<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/> Yes
Dependent				<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/> Yes
Dependent				<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/> Yes
Dependent				<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/> Yes
Dependent				<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/> Yes
**Dependent Codes: FTS - Full Time Student, DD - Disabled Dependent (If dependent is FTS or DD, UPMC Health Plan dependent forms must be completed and attached.)							
If you or any family member is covered by other group health insurance, including Medicare, please complete below: (attach separate sheets if necessary)							
Name of Member		Name of Other Group Health Insurance (including Medicare)			Policy #		
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 that I am enrolled in UPMC Health Plan I authorize, on behalf of myself and my eligible dependents and spouse, if any, all of my/our health care providers to release to UPMC Health Plan or its authorized agents all information related to my/our medical 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 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 authorize UPMC Health Plan to release such information to health care providers and 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., and UPMC Health Network, Inc. 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.							
X Signature of Employee		Mo/Day/Yr / /		X Authorization - Employer Signature		Mo/Day/Yr / /	
		Date Signed				Date Signed	

MEMBER APPLICATION AND CHANGE FORM

Please print neatly or type.

Select a Plan: HMO EPO EAPOS PPO Out of Area
 Consumer Advantage HRA Consumer Advantage HSA

You must select a plan that your employer offers.

For employer use only:

Group #: _____
 Sub-Group #: _____
 Effective Date: / /

UPMC HEALTH PLAN
Where you belong.

Applicant Status (Please Check All That Apply):

Application for Membership <input type="radio"/> Annual Enrollment <input type="radio"/> New Hire <input type="radio"/> Qualifying Event <input type="radio"/> COBRA	Change of Coverage: <input type="radio"/> Add Dependent(s) <input type="radio"/> Birth <input type="radio"/> Marriage <input type="radio"/> Drop Dependent(s) <input type="radio"/> Other <input type="radio"/> COBRA Date of Qualifying Event / /	Change of Status: <input type="radio"/> Change Address <input type="radio"/> Change Name <input type="radio"/> Select / Change PCP Former Name	Type of Coverage (check one) <input type="radio"/> Employee Only <input type="radio"/> Employee and Spouse <input type="radio"/> Employee and Child <input type="radio"/> Employee and Children <input type="radio"/> Family
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Employee Information

Last	First	Middle Initial	Social Security #	Date of Birth
Home Address / Apt. No.		City	State	Zip Code
Employer / Company Name			Date of Employment	Work Telephone

Covered Family Members

*Please use the provider index to select primary care physicians (PCPs) for yourself and each of your covered dependents.

Name (First, MI, Last)	Social Security #	Sex M F	Birth date Mo/Day/Yr	Dependent 19 or older** FTS DD	Name of PCP*	Practice #	Already a Patient?
Self		<input type="radio"/> <input type="radio"/>	/ /				<input type="radio"/> Yes
Spouse		<input type="radio"/> <input type="radio"/>	/ /				<input type="radio"/> Yes
Dependent		<input type="radio"/> <input type="radio"/>	/ /	<input type="radio"/> <input type="radio"/>			<input type="radio"/> Yes
Dependent		<input type="radio"/> <input type="radio"/>	/ /	<input type="radio"/> <input type="radio"/>			<input type="radio"/> Yes
Dependent		<input type="radio"/> <input type="radio"/>	/ /	<input type="radio"/> <input type="radio"/>			<input type="radio"/> Yes
Dependent		<input type="radio"/> <input type="radio"/>	/ /	<input type="radio"/> <input type="radio"/>			<input type="radio"/> Yes

**Dependent Codes: FTS - Full Time Student, DD - Disabled Dependent (If dependent is FTS or DD, UPMC Health Plan dependent forms must be completed and attached.)

If you or any family member is covered by other group health insurance, including Medicare, please complete below: (attach separate sheets if necessary)

Name of Member	Name of Other Group Health Insurance (including Medicare)	Policy #

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 that I am enrolled in UPMC Health Plan I authorize, on behalf of myself and my eligible dependents and spouse, if any, all of my/our health care providers to release to UPMC Health Plan or its authorized agents all information related to my/our medical 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 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 authorize UPMC Health Plan to release such information to health care providers and 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., and UPMC Health Network, Inc.

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.

X Signature of Employee	Mo/Day/Yr / /	X Authorization - Employer Signature	Mo/Day/Yr / /
	Date Signed		Date Signed

UPMC Health Plan administers benefit plans underwritten by UPMC Health Network, 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.
 UPMC Health Plan Member Services 1-888-876-2756.