UPMC Health Plan

Employee Benefit Election & Change Form

For employer use only:

Employee Name: _____
Employer Group Name: _____
Producer Name: _____
Quote ID: _____

Medical Plan Details
Group #: _____
Sub-group #: _____
Effective Date: _____

UPMC Dental and Vision *Advantage* Details
Group #: _____
Sub-group #: _____
Effective Date: _____

1. Reason for Application

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

2. Plan Description Name

Medical: _____
UPMC Dental *Advantage*: _____
UPMC Vision *Advantage*: _____

3. Change of Status/Coverage

☐ Select/Change PCP
☐ Change Address
☐ Change Name
Former Name: _____
☐ COBRA
☐ Add Dependent
☐ Drop Dependent
☐ Birth
☐ Marriage
☐ Other
☐ Date of Qualifying Event: _____

4. Employee Information

Employee Name: _____ Street Address: _____

City: _____ State: _____ ZIP Code: _____ Home Phone Number: _____

Work Phone Number: _____ First Day of Employment: _____ Retiree: ☐ Yes ☐ No

5. Covered Family Members

Name (Last, First, MI)	Social Security #	Sex (M or F)	Birth Date (Month/Day/Year)	Dependent Code*	Email Address	PCP & Practice #**
Primary (Self)						
Spouse ☐ Domestic Partner†						
Dependent Children						
1						
2						
3						
4						
5						

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

***Required for HMO plans only.*

†Not all employer groups offer domestic partner coverage. Please contact your employer group if you have questions.

6. Other Group Health Insurance

Name of covered member: _____ Name of health insurance company: _____

Policy number: _____ Effective date: _____

If you need additional space, attach a separate sheet of paper.

7. Benefit Enrollment Selection

The subscriber should make one selection for medical, dental, and vision coverage. If the subscriber waives medical, dental, or vision coverage, such coverage will not be available for the dependent(s). The dependent(s) must be enrolled in the same plan as the subscriber, unless he/she waives coverage. If dependent(s) waives coverage, he/she must mark a reason.

Name (Last, First, MI)	Medical	Dental	Vision	Waive Reason
Primary (Self)	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Covered by spouse's group coverage ☐ Spouse covered by employer's group coverage ☐ Enrolled in another insurance carrier's plan ☐ Medicare ☐ Medicaid ☐ Other: _____
Spouse ☐ Domestic Partner	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Covered by spouse's group coverage ☐ Spouse covered by employer's group coverage ☐ Enrolled in another insurance carrier's plan ☐ Medicare ☐ Medicaid ☐ Other: _____
Dependent Children	Pediatric dental and vision services will be covered for individuals under age 19 in compliance with requirements under the Affordable Care Act for members of group plans with 50 or fewer employees. However, dependents under age 19 enrolled in a UPMC Health Plan medical plan may still enroll in Standard 100/50/50/$0/$1,500/Ortho/$1,000 or Premium 100/80/50/$0/$1,500/Ortho/$1,000 — or in another carrier's employer-sponsored dental or vision plan. In cases of dual coverage, the essential health benefits (EHB) pediatric dental coverage will act as the primary coverage; Premium 100/80/50/$0/$1,500/Ortho/$1,000 will act as secondary coverage for EHB-eligible dependents.			
1	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Covered by spouse's group coverage ☐ Enrolled in another insurance carrier's plan ☐ Medicare ☐ Medicaid ☐ Other: _____
2	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Covered by spouse's group coverage ☐ Enrolled in another insurance carrier's plan ☐ Medicare ☐ Medicaid ☐ Other: _____
3	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Covered by spouse's group coverage ☐ Enrolled in another insurance carrier's plan ☐ Medicare ☐ Medicaid ☐ Other: _____
4	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Covered by spouse's group coverage ☐ Enrolled in another insurance carrier's plan ☐ Medicare ☐ Medicaid ☐ Other: _____
5	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Enroll ☐ Waive	☐ Covered by spouse's group coverage ☐ Enrolled in another insurance carrier's plan ☐ Medicare ☐ Medicaid ☐ Other: _____

Please sign here only if you are declining coverage for yourself and/or dependent(s).
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.

Signature of Employee: _____ Date: _____

Employee Name : _____

8. Tobacco Use

Tobacco use means that a person currently uses or has used tobacco an average of four or more times a week within the past six months. Tobacco includes all tobacco products. However, religious or ceremonial uses of tobacco (for example, by Native American Indians and Alaskans) are specifically exempt. **Do you or any dependents over the age of 18 use tobacco? If yes, please provide the following information.**

Name of Tobacco User	Date of Last Use	Would this tobacco user like to enroll in a tobacco cessation program with UPMC Health Plan?* Answer Yes or No.

**If you answer yes, a UPMC Health Plan health coach will contact you to discuss our tobacco cessation program. You may also enroll by calling us at 1-800-807-0751 after your effective date.*

Disclosure of Personal Health Information

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.

Authorization/Signature

I have read and agree with the terms as stated on this Employee Benefit Election & Change Form. 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 agree that all information on this Employee Benefit Election & Change Form is true and correct to the best of my knowledge and belief. I understand that this Election Form is the basis upon which coverage may be issued under the plan.

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.

_____ _____

Signature of Employee | Date

_____ _____

Signature of Spouse/Domestic Partner (if to be covered) | Date

_____ _____ _____

Signature of Employer or Employer's Agent/Authorized Representative | Title | Date

Employee Name : _____

Care Management (OPTIONAL)

The information gathered in this optional section will be used in a collaborative manner, with the focus on you, to help UPMC Health Plan provide the highest quality plan of care to you and your family. Working together, our goal is to improve your overall health. This information will not be used to set premium rates or determine eligibility for coverage.

Have you or anyone applying for coverage ever had any type of UPMC Health Plan insurance?

☐ Yes

☐ No

If yes, please provide:

Name: _____

Member ID Number (if known): _____

I authorize on behalf of myself and eligible dependents and spouse, if any, UPMC Health Plan to obtain health information to evaluate and manage care. This information cannot and will not be used to medically underwrite, set premium rates, or determine coverage eligibility. This information will be used by UPMC Insurance Services Division for all lawful purposes, including, but not limited to, medical management and implementation of health/wellness initiatives.

Any health care provider, pharmacy benefit manager, or pharmacy-related service organization having any health information about my family or me is authorized to give it to UPMC Health Plan.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

This authorization shall remain valid for 30 months from the date of signature on this application. I (we) understand the following:

- A photocopy of this authorization is as valid as the original.
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan.
- I (we) may request revocation of this authorization as described in UPMC Health Plan's Notice of Privacy Practices.
- The information that is used or disclosed in accordance with this authorization may be re-disclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.
- UPMC Health Plan cannot condition purchase in its health plan or eligibility for benefits on my (our) refusal to sign this authorization.
- I understand I have the right to retain a copy of this authorization.

_____ _____

Signature of Employee Date

_____ _____

Signature of Spouse/Domestic Partner (if to be covered) Date

Employee Name : _____

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