Enrollment Commitment Form

UPMC Health Plan

Employer Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

Tax ID: _____

Effective Date: _____

UPMC Sales Representative: _____

Agency Name: _____

Sub-Agency Name: _____

Writing Producer: _____

Producer Number: _____

Does the group require a separate sub-group?

☐ YES ☐ NO

Medical Plan 1 **Plan Design:** _____ **Rx Copayment:** _____

Tier Level	Rate	Number of Employees	Number of Members	Total Premium
Individual				$
Employee + Spouse				$
Employee + Child				$
Employee + Children				$
Family				$
TOTAL				$

Medical Plan 2 **Plan Design:** _____ **Rx Copayment:** _____

Tier Level	Rate	Number of Employees	Number of Members	Total Premium
Individual				$
Employee + Spouse				$
Employee + Child				$
Employee + Children				$
Family				$
TOTAL				$

Vision Plan **Plan Design:** _____

Tier Level	Rate	Number of Employees	Number of Members	Total Premium
Individual				$
Family				$
TOTAL				$

Dental Plan **Plan Design:** _____

Tier Level	Rate	Number of Employees	Number of Members	Total Premium
Individual				$
Family				$
TOTAL				$

Human Resources/
Billing Contact: _____

Authorized Employer
Name and Title: _____

Billing Address: _____

Authorized Employer Signature: _____ Date: _____