UPMC HEALTH PLAN

Employee Benefit Election & Change Form

For groups with 51 or more employees

For employer use only:

Employee Name: _____

Employer Group Name: _____

Start Date:

_____

1. Reason for Application

☐ Open Enrollment ☐ COBRA ☐ Qualifying Event

☐ New Hire

2. Plan Description Name

Medical: EPO No Out-of-Network Coverage

021896-800

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. Other Group Health Insurance

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

Policy number: _____ Effective date: _____

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

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/or 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 Coverage Inc., UPMC Health Options 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.

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6. Covered Family Members and Benefit Enrollment Selection

Name (Last, First, MI)	SSN (Required)	Sex (M or F)	Birth Date (Month/Day/Year)	Dependent Code*	Email Address	PCP & Practice #**
Primary (Self)						
Medical: ☐ Enroll ☐ Waive					Reason for Waiving: _____	
Spouse ☐ Domestic Partner†						
Medical: ☐ Enroll ☐ Waive					Reason for Waiving: _____	
Dependent Children						
1						
Medical: ☐ Enroll ☐ Waive					Reason for Waiving: _____	
2						
Medical: ☐ Enroll ☐ Waive					Reason for Waiving: _____	
3						
Medical: ☐ Enroll ☐ Waive					Reason for Waiving: _____	
4						
Medical: ☐ Enroll ☐ Waive					Reason for Waiving: _____	
5						
Medical: ☐ Enroll ☐ Waive					Reason for Waiving: _____	

**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.

Employee Name: _____

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 OMITTING 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 Plan Inc., UPMC Health Benefits Inc., UPMC Health Coverage Inc., and UPMC Health Options 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