

Employee Benefit Election & Change Form

For employer use only:

Employee Name: _____	Medical Plan Details	UPMC Dental and Vision Advantage Details
Employer Group Name: _____	Group #: _____	Group #: _____
Producer Name: _____	Sub-group #: _____	Sub-group #: _____
Quote ID: _____	Effective Date: _____	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

- | | | |
|--|---|--|
| <input type="checkbox"/> Select/Change PCP | <input type="checkbox"/> COBRA | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Change Address | <input type="checkbox"/> Add Dependent | <input type="checkbox"/> Other |
| <input type="checkbox"/> Change Name | <input type="checkbox"/> Drop Dependent | <input type="checkbox"/> Date of Qualifying Event: _____ |
| Former Name: _____ | <input type="checkbox"/> Birth | |

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						
<input type="checkbox"/> 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.

Employee Name : _____

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)	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Spouse covered by employer's group coverage <input type="checkbox"/> Enrolled in another insurance carrier's plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Spouse covered by employer's group coverage <input type="checkbox"/> Enrolled in another insurance carrier's plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> 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	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Enrolled in another insurance carrier's plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
2	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Enrolled in another insurance carrier's plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
3	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Enrolled in another insurance carrier's plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
4	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Enrolled in another insurance carrier's plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
5	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Enroll <input type="checkbox"/> Waive	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Enrolled in another insurance carrier's plan <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> 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 : _____

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 : _____