UPMC HEALTH PLAN

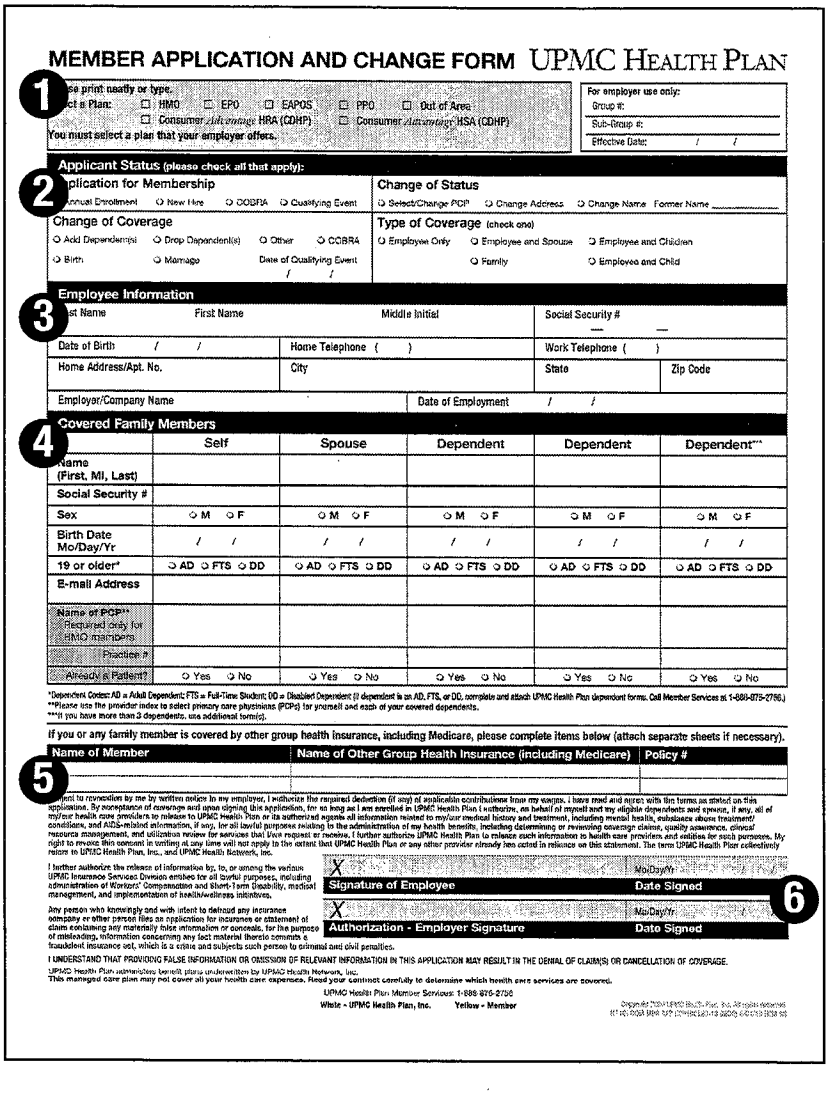
Member Application and Change Form

Instruction Sheet

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 the detailed instructions below.

❶ Select a Plan

Your open enrollment kit and/or your employer has 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.



MEMBER APPLICATION AND CHANGE FORM UPMC HEALTH PLAN

❶ Please print neatly or type.
Select a Plan: ☐ HMO ☐ EPO ☐ EAPOS ☐ PPO ☐ Out of Area ☐ Consumer *Advantage* HRA (CDHP) ☐ Consumer *Advantage* HSA (CDHP)
You must select a plan that your employer offers.

For employer use only: Group #: Sub-Group #: Effective Date: / /

❷ Applicant Status (please check all that apply):
Application for Membership: ○ Annual Enrollment ○ New Hire ○ COBRA ○ Qualifying Event
Change of Status: ○ Select/Change PCP ○ Change Address ○ Change Name Former Name
Change of Coverage: ○ Add Dependent(s) ○ Drop Dependent(s) ○ Other ○ COBRA ○ Birth ○ Marriage Date of Qualifying Event / /
Type of Coverage (check one): ○ Employee Only ○ Employee and Spouse ○ Employee and Children ○ Family ○ Employee and Child

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

❹ Covered Family Members

	Self	Spouse	Dependent	Dependent	Dependent***
Name (First, MI, Last)					
Social Security #					
Sex	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Birth Date Mo/Day/Yr	/ /	/ /	/ /	/ /	/ /
19 or older*	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD
E-mail Address					
Name of PCP** Required only for HMO members					
Practice #					
Already a Patient?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

*Dependent Codes: AD = Adult Dependent; FTS = Full-Time Student; DD = Disabled Dependent (if dependent is an AD, FTS, or DD, complete and attach UPMC Health Plan dependent form. Call Member Services at 1-888-875-2796.)
**Please use the provider index to select primary care physicians (PCPs) for yourself and each of your covered dependents.
***If you have more than 3 dependents, use additional form(s).

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

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

I request to revocation by me by written notice to my employer, I authorize the required deduction (if any) of application 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 as 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.

I further authorize the release of information 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.

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.
This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

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

UPMC Health Plan Member Services: 1-888-875-2796
White - UPMC Health Plan, Inc. Yellow - Member

❷ Applicant Status

Four boxes appear under the heading "Applicant Status." 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 check 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.

❸ 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.

❹ Covered Family Members

List full name, Social Security number, sex, date of birth, and e-mail address for yourself and 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 plan other than an HMO, you are not required to select a PCP and can leave the PCP section blank.

❺ Other Group Health Insurance

If you or any dependents who are going to be covered by UPMC 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.

❻ Signature

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

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Select a Plan: ☐ HMO ☐ EPO ☐ EAPOS ☐ PPO ☐ Out of Area
☐ Consumer *Advantage* HRA (CDHP) ☐ Consumer *Advantage* HSA (CDHP)

You must select a plan that your employer offers.

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Applicant Status (please check all that apply):

Application for Membership
○ Annual Enrollment ○ New Hire ○ COBRA ○ Qualifying Event

Change of Status
○ Select/Change PCP ○ Change Address ○ Change Name Former Name _____

Change of Coverage
○ Add Dependent(s) ○ Drop Dependent(s) ○ Other ○ COBRA
○ Birth ○ Marriage Date of Qualifying Event / /

Type of Coverage (check one)
○ Employee Only ○ Employee and Spouse ○ Employee and Children
○ Family ○ Employee and Child

Employee Information

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

Covered Family Members

	Self	Spouse	Dependent	Dependent	Dependent***
Name (First, MI, Last)					
Social Security #					
Sex	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Birth Date Mo/Day/Yr	/ /	/ /	/ /	/ /	/ /
19 or older*	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD	○ AD ○ FTS ○ DD
E-mail Address					
Name of PCP** Required only for HMO members					
Practice #					
Already a Patient?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

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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 as 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.

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X _____ Mo/Day/Yr / /
Signature of Employee **Date Signed**

X _____ Mo/Day/Yr / /
Authorization - Employer Signature **Date Signed**

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.

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UPMC Health Plan Member Services: 1-888-876-2756

White - UPMC Health Plan, Inc. **Yellow - Member**

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