UPMC Health Plan

MEMBERSHIP TERMINATION FORM

MEMBERSHIP TERMINATION FOR THE MONTH of _____ 20____

Group Number: _____

Group Name: _____

Please indicate any changes to your billing address below.

Street Address: _____

City, State, ZIP Code: _____

Contact Person: _____

Contact Phone #: _____

Contact Email: _____

This form should be used ONLY for employee terminations from your group insurance policy, vision plan, or dental plan.

DO NOT SEND THIS FORM WITH PREMIUM PAYMENTS.

To add employees to your insurance plan or to report employee status changes caused by a qualifying event, please submit the appropriate change form. You can find this form at www.upmchealthplan.com.

If you have questions about your invoice, contact UPMC Health Plan at 1-888-499-6913.

Member Name	Member ID #	Plan to Be Terminated*	Date that Coverage Ends	Reason for Termination**	Qualifying Event Code***	FW SEP (for UPMC Health Plan Use)
				UPMC Health Plan S/ENR (for UPMC HP use)		

*Plan to Be Terminated: M = Medical; D = Dental; V = Vision; A = All

**Possible reasons for termination from a group health insurance policy include resignation, dismissal from employment, retirement, death, moving out of the service area, etc.

***Qualifying event codes:

T1: Termination of employment	TX: Divorce
T8: Reduction of work hours	VM: Moved out of service area
T3: Medicare	TO: Ineligible child
ID: Death	T4: Bankruptcy of retired employee

Completed by: _____ Title: _____ Date: _____

DO NOT RETURN THIS FORM WITH YOUR PAYMENT.

Please return to:
Attn: Commercial Enrollment
UPMC Health Plan
U.S. Steel Tower, 5th Floor
600 Grant Street
Pittsburgh, PA 15219

Or fax your form to 412-454-7770.

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