UPMC HEALTH PLAN

Employee Benefit Election & Change Form

For ACA-compliant groups with 1 to 50 employees

For employer use only:

Group #: _____ Group name: _____ Employee Member ID or SSN: _____

Employee name: _____ Employer/Agent signature:_____

Instructions: Please provide the group information, member information and, upon review of the completed application, an authorized signature above. Complete part I.A for an enrollment, I.B for a change/correction/update to a member's policy, or I.C to terminate coverage. Please complete only the section below that corresponds with the reason for this request and ensure that the fields within this box are completed in full for each application. Please return to: Upload completed form using encrypted web page accessed via Employer Online > Employee Coverage tab > Enrollment Contact Form or by following link: upmchp.us/enrollment-digital-inbox Or fax to 412-454-7770

Section I. Reason for application (for employer, reason selection must be completed in its entirety)

A. Enrollment. If selecting this reason, Section II must also be completed.

1. Choose the type of enrollment

◯ New hire ◯ Open enrollment/qualifying event

1a: If qualifying event, describe: _____

2. Choose employee coverage (if waiving all coverage, select nothing, complete Section II and Section VI):

☐ Medical ☐ Dental ☐ Vision

3. Date that coverage should begin: _____/____/_____

4. Provide subgroup information:

Medical subgroup: _____ Dental/Vision subgroup: _____

5. Complete Section II (required), III IV and V. If dependents are waiving coverage, see Section VI.

B. Change/Correction

1. Choose what should be updated:

☐ Address

1a: Complete Section II with correct address

☐ Birthdate

1a: Complete Section II with name and DOB

☐ Name

1a: Former name_____

1b: Complete Section II with the correct name

☐ Plan change

1a: New subgroup_____

1b: Plan change begin date: ___/____/_____

☐ Switch to COBRA

1a: COBRA subgroup: _____

1b: COBRA begin date:___/____/_____

C. Cancel Coverage

1. Choose the type of termination:

☐ Terminate employee policy

☐ Drop dependent or spouse

1a: Name of dependent(s) to be terminated:

_____

2. Date coverage should end:_____/_____/_____

3. Plan(s) to be terminated: ☐ Medical ☐ Dental ☐ Vision

4. Termination Reason:

◯ T1 Loss of employment
◯ T8 Reduction in work hours
◯ IL Other coverage
◯ TX Divorce
◯ VM Moving out of area
◯ TO Ineligible child
◯ T3 Moving to Medicare
◯ D Death
◯ T4 Retirement
◯ Other:_____

Detach before submission

II. Employee and family information

Instructions: Complete all applicable fields. If spouse or dependents are waiving medical, dental, or vision coverage, see section IV. If section I.A was completed, you must complete this section.

Optional fields are indicated by italics.

Employee information

Employee name: _____ SSN:_____ Birthdate: ___/____/_____

*PCP & Practice ID:** _____ Sex assigned at birth: ◯ Male ◯ Female

Email address:

_____

(Use email address for ☐ General email communications ☐ Welcome kit ☐ Explanation of benefits ☐ Decline)

Mailing address: _____

City: _____ State: _____ ZIP code: _____ *Home phone number:* _____

Work phone number: _____ *First day of employment:* _____

We want to make sure that all our members get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that you and our other members receive and make sure that everyone gets the highest quality of care. See page 3 for race/ethnicity and language codes.

Race/Ethnicity: _____ *Spoken language:* _____ *Written language:* _____

Spouse information

Name: _____ SSN:_____ Birthdate: ___/____/_____

*PCP & Practice ID:** _____ Sex assigned at birth: ◯ Male ◯ Female

☐ Check if Domestic Partner ** ☐ Medical ☐ Dental ☐ Vision

Email address:

_____

(Use email address for ☐ General email communications ☐ Welcome kit ☐ Explanation of benefits ☐ Decline)

Spouse signature for electronic communication consent: _____

Race/Ethnicity: _____ *Spoken language:* _____ *Written language:* _____

*Required for HMO plans only. Search PCPs at **UPMCHealthPlan.com,** click **Find Care**

**Not all employer groups offer domestic partner coverage. Please contact your employer group if you have questions.

Detach before submission

Dependent information	
1	Name: _____ ☐ Disabled Dependent** SSN: _____ Sex assigned at birth: ☐ Male ☐ Female Birthdate: ___/___/_____ *PCP Practice ID:** _____ ☐ Medical ☐ Dental ☐ Vision
2	Name: _____ ☐ Disabled Dependent** SSN: _____ Sex assigned at birth: ☐ Male ☐ Female Birthdate: ___/___/_____ *PCP Practice ID*** _____ ☐ Medical ☐ Dental ☐ Vision
3	Name: _____ ☐ Disabled Dependent** SSN: _____ Sex assigned at birth: ☐ Male ☐ Female Birthdate: ___/___/_____ *PCP Practice ID:** _____ ☐ Medical ☐ Dental ☐ Vision
4	Name: _____ ☐ Disabled Dependent** SSN: _____ Sex assigned at birth: ☐ Male ☐ Female Birthdate: ___/___/_____ *PCP Practice ID:** _____ ☐ Medical ☐ Dental ☐ Vision
5	Name: _____ ☐ Disabled Dependent** SSN: _____ Sex assigned at birth: ☐ Male ☐ Female Birthdate: ___/___/_____ *PCP Practice ID:** _____ ☐ Medical ☐ Dental ☐ Vision

*Certification required.

Section III. Other 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.

III. Tobacco use

Tobacco use means that a person currently uses or has used tobacco an average of four or more times a week within the past six months. Tobacco includes all tobacco products. However, religious or ceremonial uses of tobacco (for example, by Native Americans and Alaska Natives) are specifically exempt. **Do you or any dependents over the age of 21 use tobacco? If yes, please provide the following information:**

Name of tobacco user	Date of last use	Would this tobacco user like to enroll in a tobacco cessation program through UPMC Health Plan?†
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

†*If you answer yes, a UPMC Health Plan health coach will contact you to discuss our tobacco cessation program. You may also enroll by calling us at* ***1-800-807-0751 (TTY: 711)*** *after your effective date.*

Detach before submission

IV. Waiving coverage

In compliance with requirements under the Affordable Care Act, pediatric dental and vision services will be covered for individuals under age 19 who are members of group plans with 50 or fewer employees. However, dependents under age 19 who are enrolled in a UPMC Health Plan medical plan may still enroll in a standard commercial dental plan, a premium commercial dental plan, 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 for the EHB-eligible dependents, and the standard or premium commercial dental plan will act as secondary coverage.

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 his or her dependent(s). The dependent(s) must be enrolled in the same plan as the subscriber, unless the dependent(s) waives coverage. If the dependent(s) waives coverage, a reason must must be marked.

Please sign here only if you are declining coverage for yourself, your spouse/domestic partner, and/or your dependent(s).

I acknowledge that I have been given the right to apply for this coverage; however, I, and/or my spouse or dependent(s), am/are electing not to enroll. I acknowledge that I, and/or my spouse/domestic partner or dependent(s), may have to wait until the plan's anniversary date to be enrolled in group coverage.

Signature of employee: _____ Date: _____

Disclosure of protected health information

By accepting 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 may release to UPMC Health Plan or its authorized agents all information related to my/our medical, dental, and 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 may release such information to health care, dental, and/or vision entities for such purposes. I understand that I have the right to revoke this consent in writing at any time, and acknowledge that my right to revoke will not apply to the extent that UPMC Health Plan or any other provider has already 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 may 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.

I have read and agree with the terms as stated on this Employee Benefit Election and 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 and Change form is true and correct to the best of my knowledge and belief. I understand that this 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.

_____ _____

Employee signature Date

_____ _____

Spouse/Domestic partner signature (if to be covered) Date

Race/Ethnicity and language

We want to make sure that all our members get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that you and our other members receive. This allows us to ensure that everyone gets the highest quality of care. We also would like to know in which language you feel most comfortable speaking with your doctor or nurse and in which language you feel most comfortable reading about your health information. See below for the race/ethnicity and language codes for use in section II.

Race/Ethnicity code	
American Indian/Alaska Native:	I
Asian:	A
Black or African American:	B
Hispanic or Latino:	H
Native Hawaiian/Other Pacific Islander:	J
White:	O
Other:	E
Declined:	5

Language code			
African languages:	AF	Navajo:	NJ
Hungarian:	HU	Yiddish:	YI
Serbo-Croation:	CR	French Creole:	FC
American Sign Language:	07	Farsi:	FA
Italian:	IT	Pennsylvania Dutch:	PD
Spanish:	ES	German:	GE
Arabic:	AR	Polish:	PL
Japanese:	JA	Other Native American languages:	ON
Tagalog:	TG	Greek:	GR
Armenian:	HY	Portuguese:	PT
Korean:	KO	Other:	OT
Thai:	TH	Gujarati:	GU
Chinese:	CH	Portugese Creole:	PC
Laotian:	LO	Decline:	DN
Urdu:	UR	Hebrew:	HE
English:	EN	Russian:	RUS
Miao Hmong:	MH	Unavailable:	UN
Vietnamese:	VI	Hindi:	HI
French:	FR	Scandinavian languages:	SC

Nondiscrimination notice

UPMC Health Plan[1] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression.

UPMC Health Plan provides free aids and services to people with disabilities so that they can communicate effectively with us. Aids and services may include:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

UPMC Health Plan provides free language services to people whose primary language is not English. Language services may include:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression, you can file a complaint with:

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-888-876-2756 (TTY: 711)
Fax: 1-412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

Translation services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-869-7228 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-869-7228（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-869-7228 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-869-7228 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-869-7228 (TTY: 711).

주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-855-869-7228 (TTY: 711) 번으로 전화해 주십시오 .

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-869-7228 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-869-7228 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-869-7228 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-869-7228 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-869-7228 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-869-7228 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-869-7228 (TTY: 711).

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ យើងមានផ្តល់សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ 1-855-869-7228 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-869-7228 (TTY: 711).

UPMC Health Plan

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

SML GRP NEW MEM APP FRM 20CG1292934 (MG) 9/30/20