Employee Benefit Election & Change Form

For ACA-compliant groups

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 Section 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. Upload the completed form by following this path: Employer OnLine > Employee Coverage tab > Enrollment Contact Form > Enroll (new enrollment) or Modify Coverage (existing enrollment). You may also fax the form to 412-454-7770.

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

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

1. Indicate the type of enrollment.

   ☐ New hire ☐ Open Enrollment ☐ Qualifying event

   1a: If qualifying event, describe: _____

2. Choose the type of coverage. (If waiving all coverage, complete Sections II and V.)

   ☐ Medical ☐ Dental ☐ Vision ☐ Waiving all coverage (Sections II and V):

3. Indicate the date coverage should begin. _____/____/_____

4. Provide subgroup information:

   Medical subgroup: _____ Dental/Vision subgroup: _____

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

B. Change, correction, or update

1. Choose what should be updated:

   ☐ Address
   - 1a: Complete Section II with correct address

   ☐ Date of birth (DOB)
   - 1a: Complete Section II with name and DOB

   ☐ Name
   - 1a: Former name: _____
   - 1b: Complete Section II with correct name

   ☐ Plan change
   - 1a: New subgroup:_____
   - 1b: Plan change start date: ___/____/_____

   ☐ Switch to COBRA
   - 1a: COBRA subgroup: _____
   - 1b: COBRA start date:___/____/_____

C. Cancel coverage

1. Choose the type of termination:

   ☐ Terminate employee policy

   ☐ Drop dependent or spouse/domestic partner
   - 1a: Name of dependent(s) to be terminated:

     _____

2. Indicate the date coverage should end. _____/_____/_____

3. Choose plan(s) to be terminated. ☐ Medical ☐ Dental ☐ Vision

4. Indicate 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 ☐ ID—Death
   ☐ T4—Retirement ☐ Other: _____

Section II. Employee and family demographics (elections)

Instructions: Complete all applicable fields. If your spouse/domestic partner or dependents are waiving medical, dental, or vision coverage, also complete Section V. If Section I.A was completed, you must complete this section.

We want to make sure that you get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the care you receive. See page 6 for race/ethnicity and language codes.

Employee:

Race/Ethnicity: _____ *Spoken language:* _____

Written language: _____ *Prefer Not to Answer:* ❑

Spouse/Domestic partner:

Race/Ethnicity: _____ *Spoken language:* _____

Written language: _____ *Prefer Not to Answer:* ❑

The fields in italics are optional and are based on self-identification. The information will be maintained as private. We will not use the information for eligibility determinations, underwriting, or rating purposes. We will not deny an application based on your refusal to answer the questions related to demographic data on the application.

Employee information

Name: _____ SSN: _____ Date of birth: ___/___/_____

PCP and Practice ID:[1] _____ Gender: ☐ Male ☐ Female ☐ Nonbinary/Other

Email address:

_____

(Use email address for: ☐ General email communications ☐ Welcome kit ☐ Explanations of Benefits ☐ Decline)

Employee signature for electronic communication consent: _____

Mailing address: _____

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

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

Spouse/Domestic partner information

Name: _____ SSN: _____ Date of birth: ___/___/____

PCP Practice ID:[1] _____ Gender: ☐ Male ☐ Female ☐ Nonbinary/Other

Coverage type: ☐ Medical ☐ Dental ☐ Vision ☐ Waiving all coverage (see Section V)

☐ Check if domestic partner[2]

Email address:

_____

(Use email address for: ☐ General email communications ☐ Welcome kit ☐ Explanations of Benefits ☐ Decline)

Spouse/Domestic partner signature for electronic communication consent: _____

[1]Required for HMO plans only. Search for PCPs by going to **upmchealthplan.com/find.**

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

Dependent information

1

Name: _____ ☐ Disabled dependent[3]

SSN: _____ Gender: ☐ Male ☐ Female ☐ Nonbinary/Other Date of birth: ___/___/___

Race/Ethnicity: _____

Spoken language: _____ *Written language:* _____ *Prefer not to answer:* ❑

PCP Practice ID:[4]_____ Coverage type: ☐ Medical ☐ Dental ☐ Vision
☐ Waiving all coverage

2

Name: _____ ☐ Disabled dependent[3]

SSN: _____ Gender: ☐ Male ☐ Female ☐ Nonbinary/Other Date of birth: ___/___/___

Race/Ethnicity: _____

Spoken language: _____ *Written language:* _____ *Prefer not to answer:* ❑

PCP Practice ID:[4]_____ Coverage type: ☐ Medical ☐ Dental ☐ Vision
☐ Waiving all coverage

3

Name: _____ ☐ Disabled dependent[3]

SSN: _____ Gender: ☐ Male ☐ Female ☐ Nonbinary/Other Date of birth: ___/___/___

Race/Ethnicity: _____

Spoken language: _____ *Written language:* _____ *Prefer not to answer:* ❑

PCP Practice ID:[4]_____ Coverage type: ☐ Medical ☐ Dental ☐ Vision
☐ Waiving all coverage

4

Name: _____ ☐ Disabled dependent[3]

SSN: _____ Gender: ☐ Male ☐ Female ☐ Nonbinary/Other Date of birth: ___/___/___

Race/Ethnicity: _____

Spoken language: _____ *Written language:* _____ *Prefer not to answer:* ❑

PCP Practice ID:[4]_____ Coverage type: ☐ Medical ☐ Dental ☐ Vision
☐ Waiving all coverage

5

Name: _____ ☐ Disabled dependent[3]

SSN: _____ Gender: ☐ Male ☐ Female ☐ Nonbinary/Other Date of birth: ___/___/___

Race/Ethnicity: _____

Spoken language: _____ *Written language:* _____ *Prefer not to answer:* ❑

PCP Practice ID:[4]_____ Coverage type: ☐ Medical ☐ Dental ☐ Vision
☐ Waiving all coverage

[3]Certification required.

[4]Required for HMO plans only. Search for PCPs by going to **upmchealthplan.com/find.**

Section III. Other health insurance

Name of covered member: _____Policy number: _____

Name of health insurance company:_____Effective date: _____

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

Section IV. Tobacco use

Tobacco use means that a person currently uses or has used tobacco an average of four or more times a week in 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 so, 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.*

Section V. Waiving coverage

In compliance with requirements of 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 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.

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 their 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 be marked.

Please sign below only if you are declining coverage for yourself, your spouse or 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/domestic partner or dependent(s) am/are electing not to enroll. I acknowledge that I, and/or my spouse/domestic partner or my dependent(s), may have to wait until the plan's anniversary date to be enrolled in group coverage.

_____ _____

Employee signature Date

Section VI. 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/domestic partner, 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 use treatment/conditions, and AIDS-related information, if any, for all lawful purposes relating to the administration of my health/dental/vision benefits. I further understand that UPMC Health Plan may release such information to health care, dental, and/or vision care entities as permitted by applicable law. The term "UPMC Health Plan" collectively refers to UPMC Health Plan Inc., UPMC Health Coverage Inc., UPMC Health Options Inc., UPMC Health Benefits Inc, and UPMC Benefit Management Services 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 health insurance policy may not cover all of your health care expenses. Read your contract or member handbook carefully to determine which health care services are covered.** Contact UPMC Health Plan Member Services at **1-888-876-2756 (TTY: 711).**

_____ _____

Employee signature Date

_____ _____

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

Race/Ethnicity and language

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

Race/Ethnicity code	
American Indian/Alaska Native:	I
Asian:	A
Black:	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-Croatian:	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	Portuguese Creole:	PC
Laotian:	LO	Decline:	DN
Urdu:	UR	Hebrew:	HE
English:	EN	Russian:	RUS
Miao Hmong:	MH	Hindi:	HI
Vietnamese:	VI	Scandinavian languages:	SC
French:	FR		

UPMC Health Plan

upmchealthplan.com

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