UPMC HEALTH PLAN
Where you belong.

MEMBERSHIP TERMINATIONS FOR

MONTH of _____, 20_____

Group Number: _____

Group Name: _____

Please indicate any changes to your billing address below.	
Street Address:	
City, State, Zip:	
Contact Person:	
Contact Phone #:	Contact E-Mail:

This form should be used ONLY for employee terminations from your group insurance policy.

DO NOT SEND WITH PREMIUM PAYMENTS.

To add employees to your insurance plan or report employee status changes caused by a qualifying event, please submit a UPMC Health Plan Member Application and Change form. Forms can be found on our website at upmchealthplan.com.

If you have questions about your invoice, please contact UPMC Health Plan at 1-888-499-6913 and select from the following options:

Group enrollment…. Option 1
Premium billing…..... Option 2

Member Name	Member ID#	Date that Coverage Ends	Reason for Termination*	Qualifying Event Code**	FW SEP (for UPMC use)
			UPMC S/ENR (for UPMC use)		

* 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:

1C: Termination of employment
2C: Reduction of work hours
3C: Medicare
4C: Death
5C: Divorce
7C: Ineligible child
8C: Bankruptcy of retired employee

Completed by: _____ Date: _____

DO NOT RETURN THIS FORM WITH YOUR PAYMENT.

Please return to:
UPMC Health Plan, Commercial Enrollment, Suite 500, One Chatham Center, Pittsburgh, PA 15219
Or fax your form to 412-454-7770.