

# SMALL GROUP EMPLOYEE APPLICATION

# UPMC HEALTH PLAN

### Applicant Status (Please Check All That Apply):

#### Application for Membership

Annual Enrollment     COBRA     Out-of-Area

For internal use only:

Group #: \_\_\_\_\_ Sub-Group #: \_\_\_\_\_ Effective Date:    /    /

### 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

Name (First, MI, Last)	E-mail Address	Social Security #	Sex		Birth Date Mo/Day/Yr	Dependent 19 or Older*			Practice #
			M	F		AD	FTS	DD	
Self			<input type="checkbox"/>	<input type="checkbox"/>	/ /				
Spouse			<input type="checkbox"/>	<input type="checkbox"/>	/ /				
Dependent			<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dependent			<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dependent			<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dependent**			<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

\*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 forms. Call Member Services at 1-888-876-2756 for the forms.)

\*\*If you have more than 4 dependents, use additional application form(s).

### Declination/Waiver of Coverage

To be completed if coverage is declined or refused by an eligible employee and/or the employee's eligible dependents:

#### Coverage Declined for:

- Employee  
 Spouse  
 Dependent(s)  
 Spouse & Dependent(s)

#### Reasons for Declining Coverage:

- Covered by spouse's group coverage  
 Enrolled in another insurance carrier's plan  
 Spouse covered by employer's group coverage  
 Medicare  
 Other:

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

Please sign here only if you are declining coverage for yourself and/or dependent(s): \_\_\_\_\_ Date: \_\_\_\_\_

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

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.

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.

<b>X</b>	Mo/Day/Yr    /    /
<b>Signature of Employee</b>	<b>Date Signed</b>
<b>X</b>	Mo/Day/Yr    /    /
<b>Authorization - Employer Signature</b>	<b>Date Signed</b>

**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.

# Medical Questionnaire (2-50 EEs)

**YOU MUST ANSWER ALL OF THE FOLLOWING QUESTIONS:**

Note: Your responses to this questionnaire will not result in any individual being excluded from the coverage being offered to your employer/plan sponsor.

## APPLICANT INFORMATION

This information MUST be completed if enrolling in a benefit plan:

Name of Employer/Plan Sponsor: \_\_\_\_\_

Applicant: \_\_\_\_\_  
First Name Last Name

**\*\* Please provide this information for yourself and each of the covered dependents. \*\***

Name (First, MI, Last)	Date of Birth	Height	Weight	Smoker?	Packs per day	# of years
Self	/ /	__ft __in		Yes No		
Spouse	/ /	__ft __in		Yes No		
Dependent	/ /	__ft __in				
Dependent	/ /	__ft __in				
Dependent	/ /	__ft __in				
Dependent	/ /	__ft __in				

**\*\* Please Complete if Applying for Coverage \*\***

Are you or any of your dependents pregnant?  Yes  No

If yes, please indicate who: \_\_\_\_\_ and estimated due date: \_\_\_\_\_

Have you or your dependents been treated for any of the following conditions? If so, check the "Yes" box, and indicate the person's initials, the date of onset, and whether the person is still under treatment or the date the treatment ended. **Do not include genetic information, including genetic testing, screenings or family history.**

**Responses for individual family members will not be used to imply or infer family history in the underwriting process.**

	Yes (Initials)	Date of Onset	Still Under Treatment? <small>Yes, or Date Treatment Ended</small>
Heart Attack			
Chest Pain/Angina			
Congestive Heart Failure			
Heart Surgery or Procedure: Bypass/Stent/Angioplasty/Valve Repair or Replacement			
Aortic/Cerebral Aneurysm			
High Cholesterol			
Peripheral Vascular Disease (PVD)/Peripheral Artery Disease(PAD)/Blood Clots			
High Blood Pressure			
COPD/Emphysema/Other Lung Disease			
Asthma			
Cystic Fibrosis			
Diabetes			
Kidney Disease/Kidney Failure/Dialysis			
Kidney Stones			
Pancreatitis			
Liver Disease/Liver Failure			
Hepatitis			
Drug Abuse/Dependence/Alcoholism			
HIV+/AIDS			
Hemophilia/Other Bleeding Disorder			
Cancer			
Leukemia/Hodgkin's/ Non-Hodgkin's Lymphoma			

	Yes (Initials)	Date of Onset	Still Under Treatment? <small>Yes, or Date Treatment Ended</small>
Depression			
Anxiety			
Bipolar Disorder			
ADD/ADHD			
Eating Disorder			
Stroke/TIA			
Migraines or Other Chronic Headaches			
Multiple Sclerosis			
Muscular Dystrophy			
Back Trouble or Back Surgery			
Immune System Disorder			
Rheumatoid Arthritis			
Osteoarthritis			
Lupus			
Crohn's Disease/Ulcerative Colitis/ Irritable Bowel Syndrome			
Diverticulosis/Diverticulitis			
Chronic Heartburn/GERD (Acid Reflux)			
Prostate/Urinary Problems			
Eye Problems			
Congenital or Genetic Disorders/ Down Syndrome			
Epilepsy/Seizure Disorder			
Organ Transplant/On Waiting List			

If "Yes" for any of the above conditions, please provide details. *If additional room is needed for detailed information, please attach a separate sheet of paper.*

Have you or any of your dependents had any illness or symptoms not previously referred to in this questionnaire?  Yes  No

**Use the space below to explain.** If additional room is needed for detailed information, please attach a separate sheet of paper.

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Have you or your dependents ever been advised to have a surgical operation or procedure that you haven't yet had done?  Yes  No

**Use the space below to explain.** If additional room is needed for detailed information, please attach a separate sheet of paper.

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List any medications or treatments you and your dependents take or receive regularly **AND** the conditions for which you take the medications.

**If additional room is needed for detailed information, please attach a separate sheet of paper.**

Name	Medication/Treatment	Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____

List below all hospital admissions for you or your dependents within the last 5 years (including mental health and chemical dependency).

If none, please write "Not Applicable." **If additional room is needed for detailed information, please attach a separate sheet of paper.**

Name	Date	Length of Stay	Reason	Result	Hospitals and Physicians
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you or your dependents receiving disability benefits of any type?  Yes  No Who? \_\_\_\_\_  
 Type of benefits \_\_\_\_\_

Any change in medical condition, and any medical treatment or advice from a physician or provider, for you or anyone on this application, that occurs after you have submitted a signed application, **must be immediately reported** to UPMC Health Plan. Coverage may be denied, canceled, or premium increased based on those changes occurring in the period between the application signature and the policy/coverage effective date. Send notification in writing to: UPMC Health Plan, Attention: Underwriting, One Chatham Center, 112 Washington Place, Pittsburgh, PA 15219.

I authorize, on behalf of myself, and eligible dependents and spouse, if any, UPMC Health Plan to obtain health information needed to underwrite or verify my application for insurance.

Any health care provider, the Medical Information Bureau (MIB), pharmacy benefit manager, pharmacy related service organization, or insurance company having any information as to a diagnosis, treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to UPMC Health Plan. This includes mental health, substance abuse treatment/conditions and AIDS-related information.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

UPMC Health Plan may release this information about my family or me to the MIB or any member company for the purposes described in UPMC Health Plan's Notice of Privacy Practices. **UPMC Health Plan's Privacy Statement and Notice of Privacy Practices may be reviewed at [www.upmchealthplan.com](http://www.upmchealthplan.com) or requested from Member Services at 1-888-876-2756.**

This authorization shall remain valid for 30 months from the date of signature on this application. I (we) understand the following:

- A photocopy of this authorization is valid as the original
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan
- I (we) may request revocation of this authorization as described in UPMC Health Plan's Notice of Privacy Practices
- UPMC Health Plan may condition purchase in its health plan or eligibility for benefits on my (our) refusal to sign this authorization, and
- The information that is used or disclosed in accordance with this authorization may be re-disclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.
- I (we) have the right to retain a copy of this authorization.

**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.**

X / / X / /  
 Employee Signature Date Signed Spouse Signature Date Signed