Please note that your signature on this application indicates your agreement to terminate any existing coverage (see Statement of understanding on page 8, item no. 5). Until you receive an acceptance letter from UPMC Health Plan, it is important that you do not cancel any other coverage. If accepted by UPMC Health Plan, you will receive an acceptance letter with the policy effective date. **Canceling your existing coverage before your new policy goes into effect will result in your being uninsured for that time period.**

When completing this application:

- You must provide the mailing address, telephone number, and Social Security number for all applicants.
- You must provide your complete address.
- You must complete all questions on this form.
- You must sign the application, along with all adults applying for coverage. Without this information, UPMC Health Plan will not be able to process your application.

Easy steps to apply:

- In black ink, carefully complete pages 2 through 9, in order.
- Return the completed application to the following address:

  ATTN: Operations, UPMC Health Plan
  U.S. Steel Tower, 600 Grant Street
  Pittsburgh, PA 15219

- Please retain a copy of this completed application.

UPMC *Advantage*

Eligibility status

Please check the box that applies to you.

☐ Are you applying during the annual Open Enrollment Period? **If yes, turn to page 3.**

☐ Are you applying because of a qualifying life event? **If yes, complete the rest of this section.**

Typically, you may enroll in a UPMC *Advantage* plan only during the annual Open Enrollment Period, November 15, 2014, through February 15, 2015. However, some situations may qualify you to enroll in a plan outside this period.

Please read the following statements carefully and check the box that applies to you. When you check a box, you are certifying that, to the best of your knowledge, you are eligible for an exception to the standard Open Enrollment Period. If we later determine that the information you provided is incorrect, you could be disenrolled from this plan.

Qualifying life event

Did you or anyone in your household lose health coverage in the **last 60 days** OR do you expect to lose it in the **next 60 days**? (Voluntarily giving up coverage or losing coverage because of failure to pay premiums does not qualify you for special enrollment.)

☐ Yes ☐ No

Did you or anyone in your household experience any of the following in the **past 60 days**?

Changes in household size:

☐ Yes ☐ No Got married
☐ Yes ☐ No Had a baby
☐ Yes ☐ No Got divorced
☐ Yes ☐ No Adopted a child or had a child placed with you for foster care
☐ Yes ☐ No Death

Changes in circumstance:

☐ Yes ☐ No Moved to a new address
☐ Yes ☐ No Had a change in income

(For people already enrolled in Marketplace coverage, this affects eligibility for premium tax credits or cost-sharing reductions.)

Changes in status:

☐ Yes ☐ No Gained citizenship or lawful presence in the U.S.
☐ Yes ☐ No Released from incarceration (prison or detention)

You have 60 calendar days from these events to enroll in a new plan. You may be asked to provide supporting documentation to prove eligibility.

Date of qualifying event _____ Requested effective date _____

Are you unable to renew current coverage because it is not compliant with the Affordable Care Act?

☐ Yes ☐ No

(You have 30 calendar days prior to your renewal date to enroll.)

Are you a member of a **federally recognized tribe**, or are you an Alaska Native corporation shareholder?

☐ Yes ☐ No

(Members of federally recognized tribes and Alaska Native shareholders can enroll in Marketplace coverage at any time of the year.)

How to determine your effective date: If you accept coverage between the first and the fifteenth of the month, your coverage will be effective the first day of the next month. If you accept coverage after the fifteenth of the month, your coverage will be effective on the first day of the **second** following month. For example, if you accept on January 15, your coverage will be effective on February 1. If you accept on January 16, your coverage will be effective on March 1.

Special cases: Newborn and newly adopted children are covered effective on the date of their birth or adoption. If you marry or if you lose minimum essential coverage, your coverage is effective on the first day of the month **after** the month in which you have accepted coverage. For example, if you accept coverage in January, your coverage will be effective February 1.

Applicant information

Name (Last, First, MI)	Marital Status	Social Security Number	Date of Birth	Age	Sex (M/F)
Primary Applicant:	☐ Married ☐ Single				
Parent/Guardian (if Primary Applicant is under 19):					
Spouse/Domestic Partner:					
Dependent Children Under 26					
a.					
b.					
c.					
d.					
e.					

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 American Indians and Alaskans) are specifically exempt. **Do you or any dependents over the age of 18 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 with UPMC Health Plan?* Answer Yes or No.

*If you answer yes and if you become a UPMC Health Plan member, a health coach may contact you to discuss our tobacco-cessation program. You may also enroll by calling us at 1-800-807-0751 after your effective date.

Primary Applicant's Address		
Street Address:		
City:	State:	ZIP Code:
PO boxes are not accepted.		
Email Address:		
☐ By checking this box, if you become a UPMC Health Plan member, you agree to receive initial plan documents **by accessing our member website.** (This includes your Policy, Schedules of Benefits, and other important information about where you can access services.)		
☐ By checking this box, you agree to receive electronic marketing communications from UPMC Health Plan and its business units or affiliates. If you do not wish to receive these communications, you may opt out by using the unsubscribe feature in the email after you receive it.		
Spouse, Domestic Partner, or Dependent's Address (if living elsewhere)		
Name of Spouse, Domestic Partner, or Dependent:		
Street Address:		
City:	State:	ZIP Code:
PO boxes are not accepted.		
Primary Applicant's Phone Number		
Home:		
Other:		

Plan selection

Instructions: On the next two pages, you will choose your medical plan and network. When you make your selection, it is important to consider the level of coverage you need, your budget, where you live, and if your provider is in the network.

1. Choose one plan.

Make one selection for your medical plan on page 5. The cost of your coverage will be influenced by deductibles, coinsurance, copayments, and out-of-pocket maximums. **The dollar amount shown is the individual deductible; the family deductible is two times that amount.** All medical plans include Essential Health Benefits coverage for pediatric dental and vision.

2. Choose one network.

Make one selection for your network on page 6. You must choose a network that is offered in the county where you live. UPMC Health Plan offers multiple network options. The network refers to where you have access to participating providers and hospitals for routine care. Participating providers in each network vary.

1. Choose one plan	Deductible Amount
Bronze	
☐ UPMC *Advantage* Bronze $6,000/$25	$6,000
☐ UPMC *Advantage* Bronze $5,500/$40	$5,500
Silver	
☐ UPMC *Advantage* Silver $3,250/$10	$3,250
☐ UPMC *Advantage* Silver HSA $2,000/20%	$2,000
☐ UPMC *Advantage* Silver $1,750/$30	$1,750
☐ UPMC *Advantage* Silver $0/$50	$0
Gold	
☐ UPMC *Advantage* Gold $750/$10	$750
☐ UPMC *Advantage* Gold $500/$15	$500
Platinum	
☐ UPMC *Advantage* Platinum $250/$20	$250
*Catastrophic	
☐ UPMC *Advantage* Catastrophic $6,600/0%	$6,600

*Catastrophic plans are offered to eligible individuals living throughout western PA. If choosing this plan, you must select the Full PPO network option in the next section.

If you have questions or want to learn more about each plan, visit www.upmchealthplan.com/coverage, call 1-877-563-0292 or contact your producer/insurance agent.

2. Choose one network

UPMC Partner Network

☐ **Network offered to individuals living in these counties:**

Allegheny
Erie

Plans in this network give you access to care from UPMC-owned facilities and providers located in all counties in western PA.

UPMC Select Network

☐ **Network offered to individuals living in these counties:**

Allegheny
Beaver
Butler
Washington
Westmoreland

Plans in this network give you access to care from participating providers located in all counties in western PA.

UPMC Premium Network

☐ **Network offered to individuals living in these counties:**

Allegheny
Armstrong
Beaver
Bedford
Blair
Butler
Cambria
Cameron
Centre
Clarion
Clearfield
Crawford
Elk
Erie
Fayette
Forest
Greene
Huntingdon
Indiana
Jefferson
Lawrence
McKean
Mercer
Potter
Somerset
Venango
Warren
Washington
Westmoreland

Plans in this network give you access to care from participating providers located in all counties in western PA.

To find out if your doctor or specialist is part of the UPMC Health Plan network, visit www.upmchealthplan.com/find, call 1-877-563-0292, or contact your provider.

Payment election

I hereby authorize UPMC Health Plan, its affiliates, and its subsidiaries to deduct insurance payments from my account at the financial institution named below.

Payer Name (if not the Primary Applicant):		
Street Address:		
City:	State:	ZIP Code:

Payment Method (You must choose one.)

Credit Card Options	
☐ Visa	Account Number:
☐ MasterCard	Expiration Date:
☐ American Express	ZIP code of credit card account holder (required for security purposes):
☐ Discover	*This is the ZIP code where the payer receives the bill.*

Or

Checking/Savings/Share Draft Account	
☐ Checking Account	Banking or Financial Institution Name:
☐ Savings Account	Routing Number:
☐ Credit Union Share Draft Account	Account Number:

IMPORTANT: The first payment is deducted immediately. UPMC Health Plan will deduct all subsequent premiums on the 20th of every month. For example, if you accept coverage on November 23, your payment will be deducted from your account immediately for your January premium. On January 20, an automatic withdrawal will be made from your account to pay your February premium.

This agreement is to remain in effect until UPMC Health Plan has received written and signed notification from me of its termination in such time and in such manner as to afford UPMC Health Plan and the depository institution a reasonable opportunity to act on the request. UPMC Health Plan will notify me in advance whenever the deduction amount or deduction day changes. UPMC Health Plan may revise the terms of this agreement at any time upon written notification. By providing payment information and submitting the application, I accept the rate for this plan.

Signature of banking or credit card holder
(as it appears on your account): _____Date: _____

Statement of understanding

Review the completed application and read the section below carefully before signing.

I have read this application or had it read to me. I represent that the answers and statements on this application are true, complete, and correctly recorded. 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 and agree that: (1) this application and the payment of the initial premium do not give me immediate coverage; (2) incorrect or incomplete information on this application may result in voidance of coverage or claim denial; (3) this completed application, and any supplements or amendments, will be made a part of any policy or certificate which may be issued; (4) the insurance producer may not change or waive any right or requirement, and is authorized to submit the application, to submit the initial premium or payment information, and to receive acceptance/denial information; (5) continuation of other coverage existing on the UPMC Health Plan effective date for more than 90 days after the effective date will void this coverage; and (6) providing false information or omitting relevant information in this application may result in the denial of claims or cancellation of coverage.

A request for new insurance coverage will require me to submit a completed application. I understand that my application will be void after 60 days if it has not been completed and submitted for review.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan, as explained in UPMC Health Plan's Notice of Privacy Practices. UPMC Health Plan may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I understand I have the right to retain a copy of this authorization. UPMC Health Plan's Notice of Privacy Practices may be reviewed at www.upmchealthplan.com or requested from Member Services at 1-855-489-3494.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you have current insurance coverage and this policy will replace it, please complete this section.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by UPMC Health Plan.* Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Omissions or misstatements in the application could cause an otherwise valid claim to be denied.

After you have completed the application and before you sign it, reread it carefully to be certain that all information has been properly recorded.

*UPMC Health Plan administers plans underwritten by UPMC Health Network Inc., UPMC Health Plan Inc., UPMC Health Coverage Inc., and UPMC Health Options Inc.

Your signature below completes your application and indicates your agreement with the check boxes you marked in this application. By signing below you acknowledge and agree that you are signing on behalf of yourself and all dependents included in this application and agree that the information you have provided on behalf of yourself and your dependents is true and correct to the best of your knowledge and belief.

☐ **I have read and completely understand the Payment election information.**
☐ **I have read and completely understand the Statement of understanding.**
☐ **I have read and completely understand the NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

_____

Signature of Primary Applicant

_____

Signature of Parent/Guardian (if Primary Applicant is a minor) Relationship

Insurance producer statement

If you worked with a producer to complete this application, please ask the producer to complete this section.

Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has read the completed application or it has been read to him or her. The applicant is fully aware that any false statement or misrepresentation may result in voidance of coverage under the policy.

Signature of Insurance Producer: _____

Print Full Name: _____

Insurance Producer Number: _____

Optional

The information gathered in this optional section will be used in a collaborative manner, with the focus on you, to help UPMC Health Plan provide the highest quality plan of care to you and your family. Working together, our goal is to improve your overall health. This information will not be used to set premium rates or determine eligibility for coverage.

Have you or anyone applying for coverage ever had any type of UPMC Health Plan insurance?
☐ Yes ☐ No

If yes, please provide the information below. If no, skip to next question.
Name: _____

Member ID Number (if known): _____

In general, compared to other people your age, would you say that your health is?

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

In the past 12 months, how many times did you go to a doctor's office or clinic?

☐ None ☐ One time ☐ Two or three times ☐ Four or six times ☐ More than six times

In the past 12 months, how many times have you been treated in the emergency department?

☐ None ☐ One time ☐ Two or three times ☐ More than three times

In the past 12 months, how many times have you stayed overnight as a patient in a hospital or nursing home?

☐ None ☐ One time ☐ Two or three times ☐ More than three times

On average, how many different prescription medicines do you take per day?

☐ None ☐ One - Four ☐ Five - Eight ☐ Nine or more

I authorize on behalf of myself and eligible dependents and spouse, if any, UPMC Health Plan to obtain health information to evaluate and manage care. This information cannot and will not be used to medically underwrite, set premium rates, or determine coverage eligibility. This information will be used by UPMC Insurance Services Division for all lawful purposes including, but not limited to, medical management and implementation of health/wellness initiatives.

Any health care provider, pharmacy benefit manager, or pharmacy-related service organization having any health information about my family or me is authorized to give it to UPMC Health Plan.

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.

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 as 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.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.
- UPMC Health Plan cannot condition purchase of its health plan or eligibility for benefits on my (our) refusal to sign this authorization.
- I understand I have the right to retain a copy of this authorization.

Signature of Primary Applicant: _____

Signature of Parent/Guardian
(if Primary Applicant is a minor): _____

Date Relationship