

Please note that your signature on this application indicates your agreement to terminate any existing coverage (see Statement of Understanding on page 10, 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. 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 12, in order.
- If you are not working with an insurance agent/producer, please return the completed application to the following address:
ATTN: Operations, UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Floor 24
Pittsburgh, PA 15219
- Please retain a copy of this completed application.

UPMC Advantage

UPMC Advantage HMO is a product of UPMC Health Plan Inc. and UPMC Health Coverage Inc. *UPMC Advantage* PPO is a product of UPMC Health Options Inc., administered by UPMC Health Plan Inc. Please note that throughout this document, we use the terms "UPMC Health Plan" and "the Health Plan" to refer to UPMC Health Options Inc., UPMC Health Coverage Inc., and UPMC Health Plan Inc. This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered.

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 1, 2015, through January 31, 2016. 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

Have any of these qualifying life events happened to you during the past 60 days?

Gained or lost a dependent because of marriage, divorce, birth, adoption, or foster care. Yes No

Lost minimum essential coverage, including losing a job-based plan, aging off a parent's coverage at 26, losing coverage through divorce, losing eligibility for Medicaid or CHIP, etc. Yes No

Death. Yes No

Moved into the service area. Yes No

Received a court order that affects insurance coverage (e.g., divorce decree or custody order). Yes No

Had a change in income that affects your eligibility for premium tax credits or cost-sharing reductions. (For people already enrolled in Marketplace coverage, this affects eligibility for premium tax credits or cost-sharing reductions.) Yes No

Gained citizenship or lawful presence in the U.S. or were released from incarceration. Yes No

Gained status in a federally recognized tribe or Alaska Native Claims Settlement Act Corp. Yes No

If you do not see your applicable qualifying event above and you are unsure if you are eligible, please contact the Federally Facilitated Marketplace at 1-800-318-2596.

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 _____

How to determine your effective date: If you accept coverage between the first and the last day of the month, your coverage may be effective the first day of the next month or the first day of the second following month. For example, if you accept on January 15, your coverage may be effective on February 1 or 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, Middle Initial)	Marital Status	Social Security Number	Date of Birth	Age	Sex (M/F)
Primary Applicant:	<input type="checkbox"/> Married <input type="checkbox"/> 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 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 Home Address (PO boxes are not accepted)

Street Address 1:		
Street Address 2:		
City:	State:	ZIP Code:
Email Address:		

Primary Applicant's Mailing Address Same as Home Address

Street Address 1:		
Street Address 2:		
City:	State:	ZIP Code:

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:
Mobile:

Plan selection

Instructions: On the next two pages, you will choose your network and medical plan. 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 network

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. Make one selection for your network. You must choose a network that is offered in the county where you live.

UPMC Partner Network

Network offered to individuals living in these counties:

Allegheny	Blair
Bedford	Erie

Plans in this network give you access to care from UPMC-owned facilities and providers located in all counties in western Pennsylvania. See below for specific counties.*

UPMC Select Network

Network offered to individuals living in these counties:

Allegheny	Washington
Beaver	Westmoreland
Butler	

Plans in this network give you access to care from participating providers located in all counties in western Pennsylvania. See below for specific counties.*

UPMC Premium Network

Network offered to individuals living in these counties:

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

Plans in this network give you access to care from participating providers located in all counties in western Pennsylvania, including Centre County. See below for specific counties in addition to Centre County.*

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.

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

2. Choose one plan

Make one selection for your medical plan. The cost of your coverage will be influenced by deductibles, coinsurance, copayments, and out-of-pocket maximums. All medical plans include Essential Health Benefits coverage for pediatric dental and vision. Optional adult dental coverage is available.

Choose one plan	Deductible Amount	
	Individual	Family
Bronze		
<input type="checkbox"/> UPMC Advantage Bronze \$6,200/\$35	\$6,200	\$12,400
Silver		
<input type="checkbox"/> UPMC Advantage Silver \$3,250/\$10	\$3,250	\$6,500
<input type="checkbox"/> UPMC Advantage Silver HSA \$2,600/20%*	\$2,600	\$5,200
<input type="checkbox"/> UPMC Advantage Silver \$1,750/\$30	\$1,750	\$3,500
<input type="checkbox"/> UPMC Advantage Silver \$0/\$50	\$0	\$0
Gold		
<input type="checkbox"/> UPMC Advantage Gold \$750/\$10	\$750	\$1,500
Platinum		
<input type="checkbox"/> UPMC Advantage Platinum \$250/\$20	\$250	\$500
†Catastrophic		
<input type="checkbox"/> UPMC Advantage Catastrophic \$6,850/0%	\$6,850	\$13,700

*If you choose to enroll in the UPMC Advantage Silver HSA \$2,600/20% plan, you are eligible to open a health savings account (HSA) and begin saving money for health care expenses. Would you like to be contacted by UPMC Health Plan's HSA partner to learn more about how to open a health savings account?

Yes No

†Catastrophic plans are offered to eligible individuals under 30 living throughout western Pennsylvania. If choosing this plan, you must select the Full PPO network option in the previous section. People 30 and older with a "hardship exemption" may buy a catastrophic plan. Financial hardship exemptions are determined by the Federally Facilitated Marketplace.

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.

3. Dental coverage

Adult dental coverage is optional. If multiple family members apply for coverage on this application, only one dental plan option can be chosen. Coverage applies to all family members on the application who are age 19 and older. Please refer to the Dominion Dental Services policies for more information.

(Access PPO Plan Policy, Form# PA15PICOC; \$30 Preventive Plan Policy, Form# PA 15UPMC-COC-2).

To find out if a dentist participates in the Dominion Dental network, please visit www.DominionDental.com/upmcdentists and select your desired dental plan in the Plan dropdown menu.

Dental coverage can be paired with a medical plan and be added only during open enrollment and renewal.

Choose a Dominion Dental Services plan:

\$30 Preventive Plan

- Fixed member copayment of \$30, per general dentist office visit, when diagnostic and preventive services are performed. Members must receive services from a participating network dentist.

Access PPO Plan

- Twice-a-year preventive services, including routine exams, cleaning, and bitewing x-rays. \$50 per insured person (\$150 family) deductible applies to all services. Member may receive services from any licensed dentist.

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. The information below is for the first month's premium payment. You can choose how you would like to make future monthly premium payments on the next page of this application.

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

First Month Payment Method (You must choose one.)

Credit Card Options

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover	Account Number:																				
	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				
	Expiration Date:																				
ZIP code of credit card account holder (required for security purposes):																					
<i>This is the ZIP code where the payer receives the bill.</i>																					

Or

Checking/Savings/Share Draft Account

<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account <input type="checkbox"/> Credit Union Share Draft Account	Banking or Financial Institution Name:
	Banking or Financial Institution Phone Number:
	Routing Number:
Account Number:	

Future Months Payment Method

- Sign me up for autopay, where my monthly premium will be deducted automatically from the account below.
- I would like to use the same information used for my initial payment for my future monthly payments (autopay).
- Do not sign me up for autopay. I would like to receive a bill and be responsible for making future payments on my own.
(Do not complete payment information below)

Credit Card Options	
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover	Account Number:
	Expiration Date:
	ZIP code of credit card account holder (required for security purposes):
	<i>This is the ZIP code where the payer receives the bill.</i>

Or

Checking/Savings/Share Draft Account	
<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account <input type="checkbox"/> Credit Union Share Draft Account	Banking or Financial Institution Name:
	Banking or Financial Institution Phone Number:
	Routing Number:
	Account Number:

IMPORTANT: The first payment is deducted within 1-2 business days upon your acceptance of coverage. If you have elected the autopay option above, 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 within 1-2 business days for your January premium. If you choose to enroll in autopay, on January 20 an automatic withdrawal will be made from your account to pay your February premium. Once you are enrolled, you can log in to MyHealth OnLine to make changes to your automatic deduction information. 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. This agreement will also terminate if an auto deduction using the payment information provided fails. 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.

Please note: if you have current coverage with UPMC Health Plan, it will not automatically terminate upon submission of this application for coverage. You must contact UPMC Health Plan separately to terminate your current coverage.

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

*UPMC Health Plan administers plans underwritten by 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 checkboxes 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: _____

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. Our goal is to work together to improve your overall health. **This information will not be used to set premium rates or determine eligibility for coverage.**

Who was your previous insurance carrier?

Aetna

Cigna

HealthAmerica

Highmark

UPMC

Policyholder Name: _____

Member ID Number: _____

Other _____

Healthy Texts on the Go

Are you trying to create a new healthy habit? Or support your work with a health coach? A daily or weekly text message offering support, advice, and tips can be just the reminder you need to stay on track.

To sign up for this FREE service from UPMC Health Plan:

- Choose a topic that interests you (you can select more than one) and text the corresponding keyword to 876247.
 - Eat better: eatright
 - Manage stress: relax
 - Manage weight: lose
 - Be more active: befit
 - Stop smoking: quit
 - Manage diabetes: regulate
- You'll get a response asking if you'd like to receive daily or weekly texts.
- Text back "1" or "STOP" at any time if you want to stop receiving texts.
- To contact a health coach, call 1-800-807-0751.

Note: Although UPMC Health Plan does not charge for the text messages, data and message rates from your carrier may apply.

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

UPMC HEALTH PLAN

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

www.upmchealthplan.com

