UPMC HEALTH PLAN

Employee Benefit Election & Change Form

For ACA-compliant groups with 2 to 50 employees

For employer use only:

Employee Name: _____
Employer Group Name: _____
Producer Name: _____
Quote ID: _____

Medical Plan Details
Group #: _____
Subgroup #: _____
Effective Date: _____

Dental and/or Vision Plans
Group #: _____
Subgroup #: _____
Effective Date: _____

1. Reason for Application

☐ Open Enrollment ☐ COBRA ☐ Qualifying Event
☐ New Hire ☐ Mini-COBRA

2. Plan Description Name

Medical: _____
UPMC Dental *Advantage*: _____
UPMC Vision Care: _____
UPMC Vision *Advantage*: _____

3. Change of Status/Coverage

☐ Select/Change PCP
☐ Change Address
☐ Change Name
Former Name: _____

☐ COBRA
☐ Add Dependent
☐ Drop Dependent
☐ Birth

☐ Marriage
☐ Other: _____
☐ Date of Qualifying Event: _____

4. Employee Information

Employee Name: _____
Street Address: _____
City: _____ State: _____ ZIP Code: _____ Home Phone Number: _____
Work Phone Number: _____ First Day of Employment: _____ Retiree: ☐ Yes ☐ No

5. Covered Family Members and Benefit Enrollment Selection

Name (Last, First, MI)	SSN (Required)	Sex (M or F)	Birth Date (Month/Day/Year)	Dependent Code*	Email Address	PCP & Practice #**
Primary (Self)						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
Spouse ☐ Domestic Partner†						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
Dependent Children						
1						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
2						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
3						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
4						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
5						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	

**FTS = Full-Time Student; DD = Disabled Dependent (certification required) **Required for HMO plans only.*

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

Employee Name: _____

Detatch before submission

5. Covered Family Members and Benefit Enrollment Selection (continued)

Pediatric dental and vision services will be covered for individuals under age 19 in compliance with requirements under the Affordable Care Act for members of group plans with 50 or fewer employees. However, dependents under age 19 enrolled in a UPMC Health Plan medical plan may still enroll in select Standard commercial dental plan or Premium commercial dental plan — or 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; Standard or Premium commercial dental plan will act as secondary coverage for 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 his or her 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, he or she must mark a reason.

Please sign here only if you are declining coverage for yourself and/or dependent(s).
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.

Signature of Employee: _____ Date: _____

6. Other Group Health Insurance

Name of Covered Member: _____ Name of Health Insurance Company: _____

Policy Number: _____ Effective Date: _____

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

7. 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, 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 after your effective date.*

Disclosure of Personal Health Information

By acceptance of 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, if any, that all of my/our health care, dental, and/or vision providers will 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 abuse treatment/conditions, and AIDS-related information, if any, for all lawful purposes relating to the administration of my health/dental/vision 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 understand that UPMC Health Plan will release such information to health care, dental, and/or vision 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 refer0s to UPMC Health Plan Inc., UPMC Health Coverage Inc., UPMC Health Options, Inc., and UPMC Health Benefits Inc.

I further understand that information will 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.

Authorization/Signature

I have read and agree with the terms as stated on this Employee Benefit Election & 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 & Change Form is true and correct to the best of my knowledge and belief. I understand that this Election 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 managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

_____ _____
Signature of Employee Date

_____ _____
Signature of Spouse/Domestic Partner (if to be covered) Date

_____ _____ _____
Signature of Employer or Employer's Agent/Authorized Representative Title Date

Detatch before submission

Nondiscrimination Notice

UPMC Health Plan[1] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UPMC Health Plan[1] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UPMC Health Plan[1]:

• Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Civil Rights Administrator.

If you believe that UPMC Health Plan[1] has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Administrator
UPMC Health Plan
600 Grant Street - 55th Floor
Pittsburgh, PA 15219

Phone: 1-844-755-5611 (TTY: 1-800-361-2629)
Fax: 1-412-454-5964
Email: HealthPlanCompliance@upmc.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Administrator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-869-7228 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-869-7228（TTY：1-800-361-2629）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-869-7228 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-869-7228 (телетайп: 1-800-361-2629).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-869-7228 (TTY: 1-800-361-2629).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-869-7228 (TTY: 1-800-361-2629)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-869-7228 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-869-7228 (رقم هاتف الصم والبكم: 1-800-361-2629).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-869-7228 (ATS : 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-869-7228 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-869-7228 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-869-7228 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-869-7228 (TTY: 1-800-361-2629).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-869-7228 (TTY: 1-800-361-2629)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-869-7228 (TTY: 1-800-361-2629).

UPMC HEALTH PLAN

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

www.upmchealthplan.com

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