

# MEMBER APPLICATION AND CHANGE FORM

Please print neatly or type.

Select One:  HMO  EAPoS  PPO

Your employer must offer the plan selected



**Please Check All That Apply:**

<input type="checkbox"/> Application for Membership	<b>Change of Coverage:</b>	<input type="checkbox"/> Add Dependent(s)	<input type="checkbox"/> Drop Dependent(s)	<b>Change of Status:</b>	<input type="checkbox"/> Change Address	<input type="checkbox"/> Change Name	<b>PPO only select one:</b>	<input type="checkbox"/> Out-of-Area: National (NPPN)
<input type="checkbox"/> Annual Enrollment	<input type="checkbox"/> Birth	<input type="checkbox"/> Marriage	<input type="checkbox"/> Other	<input type="checkbox"/> Select / Change PCP	<input type="checkbox"/> Former Name	<input type="checkbox"/> UPMC Health Benefits	<input type="checkbox"/> Preferred Healthcare System (PHS)	<input type="checkbox"/> Out-of-Area: (Ohio-Super/Mod)
<input type="checkbox"/> COBRA	<b>Date of Qualifying Event</b>	/ /	/ /			<input type="checkbox"/> Advantage	<input type="checkbox"/> Out-of-Area: WV (Select/Net)	<input type="checkbox"/> Out-of-Area: Other (MultiPlan et al)
<b>Group #</b>	<b>Division #</b>					<b>Effective Date:</b>	/ /	

**Employee Information**

Employer / Company Name \_\_\_\_\_

Mr.  Mrs.  Ms.  Dr.
 Last
First
Middle Initial
Social Security #

Home Address / Apt. No. \_\_\_\_\_
 City
State
Zip

Home Telephone ( ) \_\_\_\_\_
 Work Telephone ( ) \_\_\_\_\_

Home Address / Apt. No. \_\_\_\_\_
 City
State
Zip

Telephone ( ) \_\_\_\_\_
 State
Zip

**Type of Coverage (check one)**  Employee Only  Employee and Spouse  Employee and Child  Employee and Children  Family

Covered Family Members (Please use the Provider Directory to select a PCP for yourself and each of your covered dependents. Women also may select an OB/GYN.)

Name (First, MI, Last)	SS#	Sex	Birth date Mo/Day/Yr	Dependent 19 or older*	FTS	D	Name of PCP	Practice #	Check if Existing Patient	Name of OB/GYN	Practice #
Self		<input type="radio"/> M <input type="radio"/> F	/ /								
Spouse		<input type="radio"/> M <input type="radio"/> F	/ /								
Dependent		<input type="radio"/> M <input type="radio"/> F	/ /								
Dependent		<input type="radio"/> M <input type="radio"/> F	/ /								
Dependent		<input type="radio"/> M <input type="radio"/> F	/ /								
Dependent		<input type="radio"/> M <input type="radio"/> F	/ /								

\* Dependent Codes: FTS - Full Time Students, D - Disabled (If dependent is a FTS or disabled, proof of status must be attached)

If you or any family members are covered by another group health program, please complete below: (attach separate sheets if necessary)

Name of Member	Name of Other Group Health Program Insurance	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. My acceptance of coverage and upon signing this application for so long that I am enrolled in UPMC Health Plan/UPMC Health Benefits, I authorize, on the behalf of myself and any eligible dependents and spouse if any, all of my/our healthcare providers to release to UPMC Health Plan/UPMC Health Benefits, 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/UPMC Health Benefits 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/UPMC Health Benefits or any other provider already has acted in reliance on this statement.

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.

**UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OF COVERAGE.**

<input checked="" type="checkbox"/>	Signature of Employee	Mo/Day/Yr	/ /	<input checked="" type="checkbox"/>	Authorization - Employer Signature	Mo/Day/Yr	/ /
	Date Signed				Date Signed		

UPPMC Health Plan administers benefit plans underwritten by UPMC Health Benefits, 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.