

# Instructions for the UPMC APPLICATION for Western PA UMC

*This has been edited for informational purposes only. Please complete and submit the blank official UPMC application enclosed.*

1. **Select a Plan:** Here is where you will select either the HMO or PPO Plan.

You will also be selecting either the HSA (Health Savings Account managed by Keystone Federal UM Credit Union) or the HRA (Health Reimbursement Arrangement managed by UPMC Health Plan). Disregard Dental and Vision. You will be automatically enrolled.

2. **Reason for Application:** Open Enrollment.

3. **Change of Status:** No entry needed

4. **Type of Coverage:** Please select appropriate MEDICAL tier.

**Reason for Waiving Coverage:** No entry needed

5. **Employee Information:** Please enter your employee information.

6. **Covered Family Members:** Please enter all covered family members' information.

*Please note:* if you are choosing the HMO you must include the full Primary Care Physician's full name in the box marked PCP\*\*. You will also need to enter their Practice Number in the box marked Practice #\*\* and include if you are currently a patient. This needs to be done for any covered family members over the age of 18.

The PCP's Practice Number is NOT their telephone number. It is a UPMC code that can be located online at [www.upmchealthplan.com/](http://www.upmchealthplan.com/) find. Search the physicians name by Medical, coverage through your employer, HMO Standard Network Plan. You can also call UPMC member services for the number or ask for assistance from your Benefits Team.

7. **Other Group Health Insurance:** if you have secondary insurance coverage, please include that plan information in this box.

8. **Signature:** please sign and date on the employee signature line. The Authorized Employer signature line will be signed by your Benefits Team.

Please contact Alexis.Soohy@wpaumc.org or Kathleen.Lasky@wpaumc.org with questions.

Once complete, return to the WPAUMC Benefits Office by mail, fax (724-776-4358) or email (alexis.soohy@wpaumc.org).

Application for Open Enrollment must be received by

November 30, 2017.

**Employee Name** (First, MI, Last): INSTRUCTIONS ONLY- PLEASE FILL OUT & SUBMIT BLANK UPMC APPLICATION

**For employer use only:**

Group #: 017669 Effective date: 1/1/2018

Sub-group #: \_\_\_\_\_

Plan selection:  Medical  Dental  Vision

**1 Select a Plan**

<input type="checkbox"/> <b>HMO</b>	<input type="checkbox"/> <b>PPO</b>	Consumer Advantage	UPMC Take a Healthy Step (TAHS)	
<input type="checkbox"/> EPO	<input type="checkbox"/> PPO Out of Area	<input type="checkbox"/> HRA (CDHP)	<input type="checkbox"/> HIA	<input type="checkbox"/> <b>HSA</b>
<input type="checkbox"/> POS		<input type="checkbox"/> HSA (CDHP)	<input type="checkbox"/> <b>HRA</b>	
UPMC Dental Advantage		UPMC Vision Advantage		
<input type="checkbox"/> Basic	<input type="checkbox"/> Premium	<input type="checkbox"/> Basic	<input type="checkbox"/> Premium	<input type="checkbox"/> Wellness Only
<input type="checkbox"/> Standard		<input type="checkbox"/> Standard		

**2 Reason for Application**

**Open Enrollment**  New Hire  COBRA  Mini-COBRA  Qualifying Event  Other

**3 Change of Status/Coverage**

<input type="checkbox"/> Select/Change PCP	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Other
<input type="checkbox"/> Change Address	<input type="checkbox"/> Drop Dependent	<input type="checkbox"/> COBRA
<input type="checkbox"/> Change Name	<input type="checkbox"/> Birth	<input type="checkbox"/> Date of Qualifying Event:
Former Name: _____	<input type="checkbox"/> Marriage	_____

4 Type of Coverage	Medical	Dental	Vision	Waive
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee and Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee and Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee and Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Reasons for Waiving 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):

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**5 Employee Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Employer Name: \_\_\_\_\_ First Day of Employment: \_\_\_\_\_

Western PA Conference UMC

6 Covered Family Members	Self	Spouse	Dependent	Dependent	Dependent
Name (First, MI, Last)					
Coverage	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Social Security #					
Sex	M F	M F	M F	M F	M F
Birth Date (Month/Day/Year)	/ /	/ /	/ /	/ /	/ /
Dependent Code*			FTS DD	FTS DD	FTS DD
Email Address					
PCP**					
Practice #**					
Already a Patient?*					

\*FTS = Full-Time Student; DD = Disabled Dependent (certification required)

\*\*This section is only for HMO Members.

**7 Other Group Health Insurance**

Name of covered member: \_\_\_\_\_

Name of health insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_

Effective date: \_\_\_\_\_

**8 Signature**

I authorize the required deduction of applicable contributions from my wages on a pre-tax salary reduction basis through The Western Pennsylvania Annual Conference of The United Methodist Church Flexible Benefit Program. I understand that I cannot change or revoke my coverage election mid-year unless I have a qualified change in status and apply for a coverage change within 30 days of the event. 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 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 refers to UPMC Health Plan, Inc., UPMC Health Network, 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.

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 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., and 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.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_