SMALL GROUP EMPLOYEE APPLICATION

UPMC HEALTH PLAN

Applicant Status (Please Check All That Apply):

Application for Membership

❒ Annual Enrollment ❒ COBRA ❒ Out-of-Area

For internal use only:
Group #: Sub-Group #: Effective Date: / /

Employee Information

Last Name	First Name	Middle Initial	Social Security #
Date of Birth	Home Telephone		Work Telephone
Home Address/Apt. No.	City	State	Zip Code
Employer/Company Name			Date of Employment

Covered Family Members

Name (First, MI, Last)	E-mail Address	Social Security #	Sex M F	Birth Date Mo/Day/Yr	Dependent 19 or Older* AD FTS DD	Practice #
Self			❒ ❒			
Spouse			❒ ❒			
Dependent			❒ ❒		❒ ❒ ❒	
Dependent			❒ ❒		❒ ❒ ❒	
Dependent			❒ ❒		❒ ❒ ❒	
Dependent**			❒ ❒		❒ ❒ ❒	

*Dependent Codes: AD = Adult Dependent; FTS = Full-Time Student; DD = Disabled Dependent (If dependent is an AD, FTS or DD, complete and attach UPMC Health Plan dependent forms. Call Members Services at 1-888-876-2756 for the forms.)

**If you have more than 4 dependents, use additional application form(s).

Declination/Waiver of Coverage

To be completed if coverage is declined or refused by an eligible employee and/or the employee's eligible dependents:

Coverage Declined for: **Reasons for Declining Coverage:**

If Waiving Coverage, Information Will Appear on the Following Page(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.
Please sign here only if you are declining coverage for yourself and/or dependent(s): _____ Date: _____

If you or any family member is covered by other group health insurance, including Medicare, please complete below (attach separate sheets if necessary):

Name of Member	Name of Other Group Health Insurance (including Medicare)	Policy #

If Other Medical/Medicare Coverage Has Been Entered It Will Appear on the Following Page(s)

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. By acceptance of coverage and upon signing this application, for so long as I am enrolled in UPMC Health Plan I authorize, on behalf of myself and my eligible dependents and spouse, if any, all of my/our health care providers to release to UPMC Health Plan 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 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 or any other provider already has acted in reliance on this statement. The term UPMC Health Plan collectively refers to UPMC Health Plan, Inc., and UPMC Health Network, Inc.

I further authorize the release of information 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.

X _____ Mo/Day/Yr _____
Signature of Employee **Date Signed**

X _____ Mo/Day/Yr / /
Authorization - Employer Signature **Date Signed**

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. **This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.**

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Employee Name: ________________________________ SSN: __________________________________

Name (First, MI, Last)	E-mail Address	Social Security Number	Sex		Date of Birth (Mo/Day/Yr)	Dependent 19 or Older*		
			M	F		AD	FTS	DD
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Medical Questionnaire (2-50 EEs)

UPMC HEALTH PLAN

YOU MUST ANSWER ALL OF THE FOLLOWING QUESTIONS:

Note: Your responses to this questionnaire will not result in any individual being excluded from the coverage being offered to your employer/plan sponsor.

APPLICANT INFORMATION

This information MUST be completed if enrolling in a benefit plan:

Name of Employer/Plan Sponsor: _____

Applicant: _____

First Name Last Name

Are you or any of your dependents pregnant? ❒ Yes ❒ No

If yes, please indicate who: _____ and estimated due date: _____

**** Please provide this information for yourself and each of the covered dependents. ****

Name (First, MI, Last)	Date of Birth	Height	Weight	Smoker?	Packs per day	# of years
Self				Yes No	Tobacco Info Will Appear on the Following Page(s)	
Spouse				Yes No		
Dependent						
Dependent						
Dependent						
Dependent						

Please answer the three questions below for yourself (the employee).

1. Over the past 6 months, how would you describe your overall health compared to others your age?
   ❍ Excellent ❍ Very Good ❍ Good ❍ Fair ❍ Poor
2. In the past year, have you experienced problems with your health? ❍ Yes ❍ No
3. In the past year, excluding pregnancy, approximately how many times have you seen your doctor or clinic?
   ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ >=5

**** Please Complete if Applying for Coverage ****

Have you or your dependents been treated for any of the following conditions? If so, check the **"Yes"** box, and indicate the person's initials, the date of onset, and whether the person is still under treatment or the date treatment ended.

	Yes (Initials)	Date of Onset	Still Under Treatment? Yes or Date Treatment Ended
Heart Attack or Chest Pain (Angina)		If Medical Information Has Been Entered It Will Appear on the Following Page(s)	
Congestive Heart Failure (CHF)			
Heart Surgery/Angioplasty/Stent			
Valve Disease/Mitral Valve Prolapse			
Aneurysm (Aortic or Cerebral)			
High Cholesterol			
Peripheral Vascular Disease/Thrombosis/ Blood Clots			
High Blood Pressure			
COPD/Emphysema/Respiratory Disease/ Lung Disease			
Asthma or Use of Inhalers			
Cystic Fibrosis			
Diabetes			
Kidney Disease/Dialysis			
Pancreatitis			
Liver Disease or Hepatitis			
Drug Abuse/Dependence/Alcoholism			
HIV and/or AIDS			
Hemophilia or Other Bleeding Disorders			
Cancer			
Tumors or Cysts			
Leukemia/Hodgkin's/Non-Hodgkin's			

	Yes (Initials)	Date of Onset	Still Under Treatment? Yes or Date Treatment Ended
Psychiatric Condition/Anxiety/ Depression/Eating Disorder		If Medical Information Has Been Entered It Will Appear on the Following Page(s)	
Fibromyalgia/Chronic Fatigue/ Epstein-Barr			
Stroke/Transient Ischemic Attack/Paralysis			
Migraines or Other Chronic Headaches			
Myasthenia Gravis			
Multiple Sclerosis			
Back Trouble or Back Surgery			
Head Injury (History of Major Trauma)			
Immune System Disorder			
Rheumatoid Arthritis/Osteoarthritis			
Lupus			
Hip or Knee Replacement			
Gout			
Colitis or Diverticulosis (Chronic)			
Acid Reflux/Chronic Heartburn (GERD)			
Stomach Ulcers or Duodenal Ulcers			
Prostate or Urinary Trouble			
Eye Problems/Cataracts/Glaucoma			
Congenital Disease/Down's Syndrome			
Epilepsy or Seizure Disorder			
Organ Transplant or on Waiting List			

Employee Name: ________________________________ SSN: __________________________________

Name (First, MI, Last)	Date of Birth (Mo/Day/Yr)	Height	Weight

UPMC HEALTH PLAN

If **"Yes"** for any of the above conditions, please provide details: *If additional room is needed for detailed information, please attach a separate sheet of paper.*

Have you or any of your dependents had any illness or symptoms not previously referred to in this questionnaire? ❒ Yes ❒ No
Use the space below to explain. *If additional room is needed for detailed information, please attach a separate sheet of paper.*

Have you or your dependents ever been advised to have a surgical operation or procedure that you haven't yet had done? ❒ Yes ❒ No
Use the space below to explain. *If additional room is needed for detailed information, please attach a separate sheet of paper.*

List any medications or treatments you and your dependents take or receive regularly **AND** the conditions for which you take the medications.
If additional room is needed for detailed information, please attach a separate sheet of paper.

Name	Medication/Treatment	Conditions

If Medical Information Has Been Entered It Will Appear on the Previous Page(s)

List below all hospital admissions for you or your dependents within the last 5 years (including mental health and chemical dependency).
If none, please write "Not Applicable." *If additional room is needed for detailed information, please attach a separate sheet of paper.*

Name	Date	Length of Stay	Reason	Result	Hospitals and Physicians

If Medical Information Has Been Entered It Will Appear on the Previous Page(s)

Are you or your dependents receiving disability benefits of any type? ❒ Yes ❒ No Who? _____

Type of benefits _____

CONSENT TO USE, DISCLOSE, OR ACQUIRE PERSONAL INFORMATION TO BE INCLUDED ON ENROLLMENT FORM:
By signing this form, I agree on behalf of myself and those eligible dependents enrolled in UPMC Health Plan for whom I have the authority to enroll and to consent on their behalf (collectively "Enrollee(s)") that UPMC Health Plan may use or disclose the information contained on this enrollment form and individually identifiable health information relating to Enrollee(s) for purposes of administering my health insurance benefit, including treatment, payment, and health care operations ("TPO"), as those purposes are explained in UPMC Health Plan's Notice of Privacy Practices and to the extent permitted by law.

By signing this form, I also agree on behalf of Enrollee(s) that, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose the information set forth herein, including individually identifiable health information, that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including for TPO purposes and other purposes permitted by law.

I understand that a person who knowingly and with intent to defraud any insurance company by completing a medical questionnaire with false information or by omitting relevant information commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

X _____ _____
Employee Signature **Date Signed**

X _____ / /
Spouse Signature **Date Signed**