

# Student Health Insurance Plan Enrollment Form

Application information			Term and payment options		
Last	First	Middle Initial	<b>I am enrolling for:</b> <input type="checkbox"/> Annual benefit period (8/1/09 to 7/31/10) <input type="checkbox"/> Spring benefit period (1/1/10 to 7/31/10)		
Social Security #	Date of Birth				
Mailing address			<b>I am enclosing premium payment for:</b> <input type="checkbox"/> the entire annual benefit period <input type="checkbox"/> the first half of the annual benefit period. I understand that I must remit my premium payment for the second half of the annual benefit period by 1/15/10 to avoid a lapse in coverage. <input type="checkbox"/> the entire spring benefit period  <b>Credit/Debit Payment</b> Please call the student payment line at 1-800-889-2193 to make the payment.  <small>NOTICE TO STUDENTS: If the University of Pittsburgh determines that you do not qualify as an eligible full-time student, your coverage will be terminated retroactive to the effective date, and no premium will be refunded.</small>		
Permanent Street Address / Apt. #					
City / State		Zip			
Permanent Telephone	Permanent E-mail				
Billing address, if different from above					
College Street Address / Apt. #					
City / State		Zip			
College Telephone	College E-mail				
Covered family members					
Name (First, MI, Last)	Sex	Date of Birth	Social Security Number		
Self	M F	/ /	- -		
Spouse	M F	/ /	- -		
Dependent	M F	/ /	- -		
Dependent	M F	/ /	- -		
<input type="checkbox"/> For more than 2 dependents, check this box, then sign and attach an additional enrollment form.					
If you or any family members are covered by other group health insurance, including Medicare, please complete below					
Name of Member	Name of other group health insurance	Policy Number			

**To enroll, please return this application with payment to: UPMC Health Plan  
One Chatham Center  
112 Washington Place  
Pittsburgh, PA 15219**

**For more information please call: 1-888-499-6885**

I have read and agree with the terms as stated on this application. By acceptance of coverage upon signing this application for so long as I am enrolled in UPMC Health Network, Inc., I authorize, on the behalf of myself and my eligible dependents and spouse if any, all of my/our health care providers to release to UPMC Health Plan/Health Network, Inc., 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 Network, Inc., 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 Network, Inc., 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 any 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.

Student Signature	Date Signed
<b>X</b>	Mo/Day/Yr      /      /