

Student Health Insurance Plan Enrollment Form

Application information			Term and payment options
Last	First	Middle Initial	I am enrolling for: <input type="checkbox"/> Annual benefit period (9/1/10 to 8/31/11) <input type="checkbox"/> Spring benefit period (1/1/11 to 8/31/11) I am enrolling in: <input type="checkbox"/> Standard Plan <input type="checkbox"/> Enhanced Plan I am enclosing premium payment for: <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 2/15/11 to avoid a lapse in coverage. <input type="checkbox"/> the entire spring benefit period Credit/Debit Payment Please call the student payment line at 1-800-889-2193 to make the payment. 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.
Social Security #	Date of Birth		
Mailing address			
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	/ /	- -

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
X	Mo/Day/Yr / /