

## DEPENDENT CARD REQUEST FORM

Mail to:  
UPMC Health Plan  
P.O. Box 2976  
Pittsburgh, PA 15230

Phone: 1-888-876-2756  
Fax: 412-454-2796

No. of pages \_\_\_\_\_

## PLAN INFORMATION

EMPLOYER NAME: \_\_\_\_\_

## EMPLOYEE INFORMATION

\_\_\_\_\_  
First Name MI Last Name

\_\_\_\_\_  
Member ID Number Daytime Phone Number Email Address

## DEPENDENT INFORMATION

Please list eligible dependent, as defined by IRC §152, to whom a Benefits Card should be issued.

\_\_\_\_\_  
Dependent First Name MI Last Name

\_\_\_\_\_  
Social Security Number Date of Birth

## EMPLOYEE AUTHORIZATION

By providing dependent information and signing the Dependent Card Request Form I authorize and understand that one additional Benefit Card will be issued under the *MyFlex Advantage* plan. A card will only be issued to an eligible dependent, 18 years of age or older, as defined by IRC §152. **Use of the card will directly affect my account balance.** I am fully responsible to ensure that my dependent complies with the rules and regulations regarding the use of the card as outlined in the cardholder agreement to which I agree to be bound.

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

Reviewed by UPMC Health Plan: \_\_\_\_\_