

# UPMC HEALTH PLAN

**MEMBERSHIP TERMINATIONS FOR**  
**MONTH of \_\_\_\_\_, 20\_\_\_\_\_**

**Group Number:** \_\_\_\_\_

**Group Name:** \_\_\_\_\_

Please indicate any changes to your billing address below.	
Street Address:	
City, State, Zip:	
Contact Person:	
Contact Phone #:	Contact E-Mail:

This form should be used **ONLY** for employee terminations from your group insurance policy.

**DO NOT SEND WITH PREMIUM PAYMENTS.**

To add employees to your insurance plan or report employee status changes caused by a qualifying event, please submit a UPMC Health Plan Member Application and Change Form. The form can be found on our website at [www.upmchealthplan.com](http://www.upmchealthplan.com).

If you have questions about your invoice, please contact UPMC Health Plan at 1-888-499-6913.

Member Name	Member ID #	Date That Coverage Ends	Reason for Termination*	Qualifying Event Code**	FW SEP (for UPMC use)
UPMC S/ENR (for UPMC use)					

\* Possible reasons for termination from a group health insurance policy include resignation, dismissal from employment, retirement, death, moving out of the service area, etc.

\*\* Qualifying event codes:

- |                               |                                    |
|-------------------------------|------------------------------------|
| 1C: Termination of employment | 5C: Divorce                        |
| 2C: Reduction of work hours   | 7C: Ineligible child               |
| 3C: Medicare                  | 8C: Bankruptcy of retired employee |
| 4C: Death                     |                                    |

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

**DO NOT RETURN THIS FORM WITH YOUR PAYMENT.**

Please return to:  
 Attn: Commercial Enrollment, UPMC Health Plan, US Steel Tower, 23rd Floor, 600 Grant Street, Pittsburgh, PA 15219  
 Or fax your form to 412-454-7770.