UPMC *for Life*

UPMC Health Plan Medicare Program

HOP
HEALTH OPTIONS PROGRAM
WWW.HOPBENEFITS.COM®

EMPLOYER GROUP PLAN APPLICATION FORM

If you have questions about this form, please call us at 1-877-381-3765. TTY users should call 1-800-361-2629.

OFFICE USE ONLY		
Plan ID#:	Effective Date:	
ICEP/IEP:	AEP:	SEP (type):
Plan Representative/Broker:		
If you assisted with this application, sign and date here:		

Please contact UPMC for Life if you need information in another language or format (e.g., audio).

1. TO ENROLL, PLEASE PROVIDE THE FOLLOWING INFORMATION

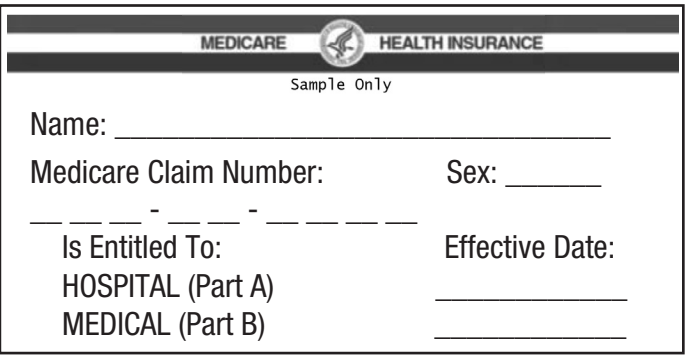
Name:		Phone number:	
Date of birth: (mm/dd/yyyy)		Sex: ☐ Male ☐ Female	
Permanent residence address:			
City:	State:	Zip code:	County:
Email address (optional):	Do we have your permission to send you information (e.g., newsletters) via email? ☐ Yes ☐ No		
Mailing address (Complete only if different from your permanent residence address):			
Street address:			
City:	State:	Zip code:	County:

2. SPONSORING GROUP

Name of Group: **PSERS Health Options Program HMO Plan** Group #: **MC0143**

3. MEDICARE INFORMATION

Please fill in the card to the right with the information from your red, white, and blue Medicare card. Otherwise, please attach a copy of your Medicare card or letter from Social Security or the Railroad Retirement Board. You must have Medicare Parts A and B to join our Plan.



4. SELECT A PRIMARY CARE PHYSICIAN (PCP)

Name of selected PCP:_____ PCP # (from provider directory): _____

5. OTHER HEALTH INSURANCE INFORMATION

Are you the retiree? ☐ Yes ☐ No	Do you or your spouse work full time? ☐ Yes ☐ No
Will you have other medical or presciption drug coverage in addition to UPMC *for Life*? ☐ Yes ☐ No If "yes" please provide your identification (ID) numbers for this coverage:	
Insurance company:	Subscriber name:
Subscriber ID number:	Subscriber group number:

6. ALTERNATIVE FORMAT OPTIONS

If you require information in an alternative format, please check one of the boxes below or contact UPMC *for Life* at the phone number provided on page 1 of this application.

☐ Audio ☐ Large print ☐ Braille ☐ Language (please list) _____

Please Read and Sign Below:

1. UPMC *for Life* is a Medicare Advantage plan that has a contract with the federal government. Enrollment in UPMC *for Life* depends on contract renewal. I understand that enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes ONLY at certain times of the year (as determined by my employer group sponsor), or under certain special circumstances (e.g., moving out of the area). I will need to keep my Medicare Part A and B coverage. I understand that I can be member of only one Medicare Advantage plan at a time and that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan, if applicable.

2. I understand that beginning on the date my UPMC *for Life* coverage begins I must get all of my health care and prescription drugs from this plan's network providers, except for emergency or urgently needed services or out-of-area dialysis services. Services prior authorized by UPMC *for Life* and other services contained in my UPMC *for Life* Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. If a service requires an authorization and one is not obtained, **neither Medicare nor UPMC *for Life* will pay for the service**.

3. UPMC *for Life* serves a specific service area. If I move out of the area, I need to notify the plan so I can disenroll and find a new plan in my new area.

4. I understand that, as a member of UPMC *for Life*, I have the right to appeal plan decisions about payments, services, or prescription drugs if I disagree. I will read the Evidence of Coverage document from UPMC *for Life* when I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan.

5. **Release of Information:** By enrolling in the UPMC *for Life* HMO plans, I acknowledge that UPMC *for Life* will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.

6. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

7. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application form means that I have read and understand the contents of this form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by UPMC *for Life* or by Medicare.

Signature:	**Today's date:**

If you are the authorized representative, you must sign above and provide the following information:

Name:	Relationship to enrollee:
Address:	Phone number:

Please mail completed form in the enclosed envelope or mail to:
PSERS Health Options Program, P.O. Box 1764, Lancaster, PA 17608-1764.

White copy: PSERS-HOP/UPMC *for Life* Duplicate copy: Member