

EMPLOYER GROUP PLAN  
Plan Application Form

**If you have questions about this form, please call us at 1-866-517-2803. 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 application, sign and date here:		

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

## I. TO ENROLL, PLEASE PROVIDE THE FOLLOWING INFORMATION

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

## 2. SPONSORING GROUP

Name of Group: <b>REHP HMO Plan</b>	Group #: <b>MC6339</b>
-------------------------------------	------------------------

## 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.

MEDICARE HEALTH INSURANCE	
<small>Sample Only</small>	
Name: _____	
Medicare Claim Number: _____	Sex: _____
Is Entitled To: HOSPITAL (Part A) MEDICAL (Part B)	Effective Date: _____ _____

## 4. SELECT A PRIMARY CARE PHYSICIAN (PCP)

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

## 5. OTHER HEALTH INSURANCE INFORMATION

Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your spouse work full time? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will you have other medical coverage in addition to UPMC <i>for Life</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> 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. I will need to keep my Medicare Parts A and B coverage. I understand that I can enroll in only one Medicare Advantage plan at a time and 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).
2. I understand that beginning on the date my UPMC *for Life* coverage begins I must get all of my health care from this plan's network of 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 or services 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 plan, 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 **postage paid envelope** or mail to: UPMC *for Life*, P.O. Box 2967, Pittsburgh, PA 15230.  
Or you can fax the information to UPMC *for Life* at 412-454-7766.

White copy: UPMC *for Life*

Duplicate copy: Member

