Member Application & Change Form

UPMC Vision *Advantage*

For new enrollment, please complete ALL sections of this form. For enrollment changes, please complete the applicable "Type of Activity" change(s) in Section A, the identification number in Section B, and the dependent changes in Section C.

For employer use only:
Group #:
Sub-Group #:
Effective Date: / /

Applicant Status (please check all that apply):

Type of Coverage

☐ Basic ☐ Standard ☐ Premium

Effective Date

/ /

Type of Activity

☐ Annual Enrollment ☐ New Hire
☐ Add Dependent(s) ☐ Drop Dependent(s) ☐ Name Change ☐ Other
☐ Birth ☐ Marriage Date of Qualifying Event / /

Type of Coverage (check one)

☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child
☐ Employee and Children ☐ Family ☐ Waived Reason: _____

Employee Information

Last Name	First Name	Middle Initial	Social Security # — —
Date of Birth / /	Home Telephone ( )		Work Telephone ( )
Home Address/Apt. No.	City	State	Zip Code
Employer/Company Name		Date of Employment / /	

Covered Family Members

	Self	Spouse	Dependent	Dependent	Dependent***
Name (First, MI, Last)					
Social Security #					
Sex	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Birth Date Mo/Day/Yr	/ /	/ /	/ /	/ /	/ /
19 or older*	☐ AD ☐ DD	☐ AD ☐ DD	☐ AD ☐ DD	☐ AD ☐ DD	☐ AD ☐ DD
E-mail Address					

*Dependent Codes: AD = Adult Dependent (as per eligibility rider); DD = Disabled Dependent (If dependent is an AD or DD, complete and attach UPMC Health Plan dependent forms. Call Member Services at 1-877-499-6914.)
***If you have more than 3 dependents, use additional form(s).

If you or any family member is covered by other vision insurance, including Medicare, please complete items below (attach separate sheets if necessary).

Do you or your dependent(s) have other Group Vision Coverage? Yes ☐ No ☐
If your answer is yes, please complete the following information

Policy Holder	Insurance Company	Policy/Identification	Effective Date (mm/dd/yyyy)

Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) of applicable contributions from my wages. I have read and agree with the terms as stated on this application. By acceptance of coverage, and upon signing this application, for so long as I am enrolled in UPMC Vision *Advantage*, I authorize, on behalf of myself and my eligible dependents and spouse, if any, all of my/our health care providers to release to UPMC Health Plan or its authorized agents all information related to my/our medical history and treatment that are relevant to the dental care included under this coverage. This may include substance abuse treatment/conditions, and AIDS-related information, if any, for all lawful purposes relating to the administration of my dental/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 to release such information to dental and/or 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 or any other provider has already acted in reliance on this statement.

I further authorize the release of information by, to, or among the various UPMC Insurance Services Division entities for all lawful purposes, including administration of Workers' Compensation and Short-Term Disability, medical management, and implementation of health/wellness initiatives.

Any person who knowingly and with the 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, 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.

Employee Signature _____ **Date** _____

Employer Signature _____ **Date** _____

The term UPMC Health Plan collectively refers to UPMC Health Plan, Inc., UPMC Health Benefits, Inc., and UPMC Vision *Advantage*.

White - UPMC Health Plan, Inc. **Yellow - Member**