[UPMC Individual *Advantage*]

APPLICATION FOR RENEWABLE HEALTH INSURANCE

Please note that your signature on this application indicates your agreement to terminate any existing coverage (see Statement of Understanding, page 6, item no. 5). HOWEVER UNTIL YOU RECEIVE AN ACCEPTANCE LETTER FROM UPMC HEALTH PLAN, IT IS IMPORTANT THAT YOU DO NOT CANCEL ANY OTHER COVERAGE. If accepted by UPMC Health Plan, you will receive an acceptance letter with the policy effective date. **CANCELING YOUR EXISTING COVERAGE PRIOR TO THE POLICY EFFECTIVE DATE WILL RESULT IN YOUR HAVING UNINSURED DAYS.**

To be filled out personally by the applicant(s) PLEASE PRINT IN BLACK INK

APPLICANT(S) INFORMATION (only list person applying for coverage)

Name (Last, First, M.I.)		Marital Status	Social Security No.	Birth Date	Age	Sex	Height	Weight
1. Primary (You)		☐ M ☐ S						
2. Spouse								
3. Dependent Children		Not required	Social Security No.	Birth Date	Age	Sex	Height	Weight
a.								
b.								
c.								
d.								
e.								
f.								
g.								
h.								

4. Primary Applicant's Address:

E-mail (This will be our primary means of contact.)

Street (P.O. Boxes are not accepted.)

City State ZIP

5. Spouse's or Dependent's Address if living elsewhere: (P.O. Boxes are not accepted):

Name of spouse or dependent

Street

City State ZIP

6. Phone Numbers:

N/A

Home Other Best number and time to call

7. Your Occupation: **Date Hired:**

Prior Employment (if within 2 years):

COVERAGE INFORMATION

8. Requested Effective Date:

UPMC Health Plan cannot guarantee that your requested effective date can be met. You will be notified of the effective date of coverage, which is usually the first day of the month following medical underwriting approval. The effective date of coverage is the date on which your coverage begins following UPMC Health Plan medical underwriter approval and assignment of an effective date.

CHOOSE A PLAN

9. Renewable Exclusive Provider Organization (EPO) and Qualified High-Deductible Plans (QHDP); Choose One Plan design:

Individual *Advantage* Value Plans (EPO)*

- ☐ Value $500
- ☐ Value $1,000
- ☐ Value $0
- ☐ Value $2,500
- ☐ Value $5,000

Individual *Advantage* Savings Plus (QHDP)*

- ☐ Saving Plan $1,300
- ☐ Saving Plan $2,500
- ☐ Savings Plan $5,000

*The amount shown is the individual deductible; the family deductible is two times the amount shown.

OTHER COVERAGE

10. Have you, or anyone applying for coverage, been previously denied, rated, or charged an extra premium, or had health conditions excluded or riders applied to life or health insurance coverage? ☐ Yes ☐ No If yes, list name and give details.

Name ____________________ Company ____________________ Action Taken ____________________

Date ____________ Reason for Action ______________________________

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. You could incur criminal and civil penalties.

11. Do you or anyone applying for coverage have other health insurance coverage, including Medicare? ☐ Yes ☐ No

If yes, complete the chart below. **Your signature on this application indicates your agreement to terminate any existing coverage if [UPMC Individual *Advantage*] Guaranteed Renewable coverage is accepted (see item no. 5 under Statement of Understanding).**

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

12. Have you or anyone applying for coverage ever had any type of UPMC Health Plan insurance? ☐ Yes ☐ No If yes, please provide:

Name ____________________ Termination Date (if known) ____________ Member# (if known) ____________

If you or anyone applying for coverage was a prior UPMC Health Plan member, please select the type of coverage:

- ☐ [UPMC Individual *Advantage*] Short Term
- ☐ [UPMC Individual *Advantage*] Guaranteed Renewable
- ☐ UPMC *for You* Medical Assistance Program
- ☐ UPMC *for Life* Specialty Plan Medicare Program
- ☐ UPMC Health Plan, group coverage
- ☐ UPMC *for Life* Medicare Program
- ☐ UPMC *for Kids* Pennsylvania Children's Health Insurance Program (CHIP)

ADDITIONAL INFORMATION

13. During the next two years does the applicant plan to participate in the following activities: motorized vehicle racing, bungee jumping, rock climbing, rodeo events, scuba diving, ultralight flying, crop dusting? ☐ Yes ☐ No

14. In the past five years, have you or anyone applying for coverage been convicted of or cited for driving under the influence of alcohol or drugs? ☐ Yes ☐ No

MEDICAL HISTORY – FOR ALL APPLICANTS

In the past 10 years, have you or anyone applying for coverage been prescribed medication by, diagnosed by, received any other treatment, advice, testing or surgery by a medical professional for any disorder, injury, disease, illness, adverse finding, or abnormal test result related to any of the following?

You must answer Yes or No for each and every question below, or this application cannot be processed. "Medical History Details" must be supplied for each Yes response in the chart under item no. 38 (below). **Do not include genetic information, including genetic testing, screenings, or family history. Responses for individual family members will not be used to imply or infer family history in the underwriting process.**

UPMC Health Plan may require more information to accurately process your application. A Health Plan representative may call you to discuss your entries on this application and the Health Plan may also require an Attending Physician Statement based on your medical records. (Charges or fees at the physician's office for medical records and Physician Statements are the applicant's responsibility.) **UPMC Health Plan will be unable to process the application if the required additional information is not supplied by the applicant.**

15. Cardiovascular System (heart and blood vessels)

	Yes	No
Anemia	☐	☐
Aortic or cerebral (brain) aneurysm	☐	☐
Blood or circulatory disorder	☐	☐
Cardiomyopathy	☐	☐
Congestive heart failure (CHF)	☐	☐
Heart disease (coronary artery disease) or heart valve disease	☐	☐
Hemophilia or other bleeding disorder	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Pacemaker or defibrillator	☐	☐
Palpitations or abnormal heart rhythm	☐	☐
Peripheral vascular disease/thrombosis/blood clots	☐	☐
Stroke	☐	☐
Transient ischemic attack (TIA) or mini stroke	☐	☐
Varicose veins, edema, or phlebitis	☐	☐

16. Respiratory System (lungs/breathing)

	Yes	No
Allergy or use of allergy shots	☐	☐
Asthma or use of inhalers	☐	☐
Chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis	☐	☐
Cystic fibrosis	☐	☐
Pneumonia	☐	☐
Sleep apnea	☐	☐
Tuberculosis	☐	☐

17. Nervous System (brain and spinal cord)

	Yes	No
Alzheimer's, dementia, or memory Loss	☐	☐
Amyotrophic lateral sclerosis (ALS)	☐	☐
Cerebral palsy	☐	☐
Epilepsy, seizure disorder, or tremors	☐	☐
Head injury or history of major trauma	☐	☐
Migraines or other chronic headaches	☐	☐
Multiple sclerosis	☐	☐
Muscular dystrophy	☐	☐
Myasthenia gravis	☐	☐
Paraplegia or quadriplegia	☐	☐
Parkinson's disease	☐	☐
Restless leg syndrome	☐	☐

18. Skin Disorder

	Yes	No
Burns	☐	☐
Cosmetic or reconstructive surgery	☐	☐
Discoid lupus	☐	☐
Shingles	☐	☐
Psoriasis	☐	☐
Tumors/cysts /polyps/lump or growth of any kind	☐	☐

19. Muscular or Skeletal System (bone, joints, tendons, muscles)

	Yes	No
Amputation	☐	☐
Back/neck/spine pain, injury, or trouble	☐	☐
Carpal tunnel syndrome	☐	☐
Fibromyalgia/chronic fatigue syndrome/Epstein Barr	☐	☐
Gout	☐	☐
Implant/use of prosthetic devices/limbs	☐	☐
Jaw disease or disorder such as, but not limited to, temporomandibular joint disorders (TMJ)	☐	☐
Joint replacement such as, but not limited to, hip or knee	☐	☐
Osteoarthritis	☐	☐
Rheumatoid arthritis	☐	☐

20. Digestive System

	Yes	No
Acid reflux/chronic heartburn (GERD)	☐	☐
Biliary cirrhosis	☐	☐
Cirrhosis of the liver	☐	☐
Crohn's disease	☐	☐
Diverticulosis or diverticulitis	☐	☐
Esophageal varices	☐	☐
Gallbladder disease or disorder or gallstones	☐	☐
Hepatitis C	☐	☐
Irritable bowel syndrome	☐	☐
Liver disease (other)	☐	☐
Obesity treatment, including weight loss surgery	☐	☐
Pancreatitis or other disease of pancreas	☐	☐
Stomach or duodenal ulcers	☐	☐
Ulcerative colitis	☐	☐

21. Urinary System (kidney and bladder)

	Yes	No
Interstitial cystitis	☐	☐
Kidney failure/dialysis	☐	☐
Kidney stones	☐	☐
Polycystic kidney disease	☐	☐
Recurrent bladder or kidney infections	☐	☐
Urinary incontinence or frequency	☐	☐

22. Male Reproductive System

	Yes	No
Herpes	☐	☐
Infertility	☐	☐
Penile or testicular disorder	☐	☐
Prostate trouble, prostatitis, or elevated PSA	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted disease	☐	☐

23. Female Reproductive System

	Yes	No
Breast disorder such as, but not limited to, fibroid tumor, lumps, and implants	☐	☐
Complication of pregnancy or prior cesarean section	☐	☐
Endometriosis	☐	☐
Herpes	☐	☐
Ovarian cysts	☐	☐
Reproductive disorder/infertility	☐	☐
Sexually transmitted disease	☐	☐
Uterine fibroids	☐	☐

24. Endocrine, Gland, or Metabolic

	Yes	No
Diabetes or sugar in the blood or urine	☐	☐
Thyroid or other gland disorder or disease	☐	☐
Weight fluctuation (+ or - 15 pounds)	☐	☐

25. Cancer

	Yes	No
Cancer of any internal organ	☐	☐
Chemotherapy or radiation treatment	☐	☐
Leukemia/Hodgkin's/non-Hodgkin's lymphoma	☐	☐
Metastatic cancer	☐	☐
Skin cancer	☐	☐

26. Congenital Disease, Abnormality, or Birth Defect

	Yes	No
Cleft lip/palate or club foot	☐	☐
Developmental delay	☐	☐
Down syndrome	☐	☐
Mental retardation	☐	☐
Sickle-cell anemia	☐	☐
Skull or facial deformities	☐	☐

27. Psychiatric, Emotional, or Behavioral

	Yes	No
ADD or ADHD	☐	☐
Anxiety	☐	☐
Autism or Asperger's syndrome	☐	☐
Bipolar disorder or schizophrenia	☐	☐
Depression	☐	☐
Eating disorder such as, but not limited to, anorexia or bulimia	☐	☐
Other psychiatric disorder	☐	☐

MEDICAL HISTORY – FOR ALL APPLICANTS *(continued)*

28. Eye or Ear Disorder

	Yes	No
Blindness or Blurred Vision	☐	☐
Cataracts	☐	☐
Detached retina	☐	☐
Glaucoma	☐	☐
Hearing impairment	☐	☐
Macular degeneration	☐	☐
Meniere's disease, labyrinthitis, or vertigo	☐	☐

29. Immune System Disorder

	Yes	No
AIDS, HIV + or ARC	☐	☐
Systemic lupus erythematosus	☐	☐

Other ______________________________

30. Organ Transplant or on the Waiting List..................
(Donor or Recipient) ☐ Yes ☐ No

31. In the past five years, regarding alcohol or drug dependency or abuse, or any use of illegal drugs, have you or anyone applying for coverage been advised to seek treatment (including counseling) by, been treated by, or discussed treatment with, a medical professional?.. ☐Yes ☐No

32. Has any person on this application used tobacco products in any form, including cigarettes, cigars, or smokeless tobacco in the last five years? .... ☐Yes ☐No

Name: ____________ Type of Product: ____________ Packs/Day: ____ No. of Years: ____
Name: ____________ Type of Product: ____________ Packs/Day: ____ No. of Years: ____
Name: ____________ Type of Product: ____________ Packs/Day: ____ No. of Years: ____
Name: ____________ Type of Product: ____________ Packs/Day: ____ No. of Years: ____

33. Are you, the applicant, or any family member pregnant, an expectant parent, or in the process of adoption, whether or not listed on this application? .... ☐Yes ☐No

If yes, name: ______________________ Due Date: ____________
name: ______________________ Due Date: ____________
name: ______________________ Due Date: ____________
name: ______________________ Due Date: ____________

34. In the past five years, have you or anyone applying for coverage been prescribed medication by, diagnosed by, or received any other treatment by, a medical professional for any other disorder, injury, disease, illness, adverse finding or abnormal test result or medical or psychiatric condition **not already disclosed in this application? ....** ☐Yes ☐No
If yes, provide details under Medical History Details.

35. Have you or anyone listed on this application been advised by a medical professional to have, or have you already scheduled, an operation or medical procedure not yet performed?.. ☐Yes ☐No

If yes, please provide details and dates:

____

36. List any medications or treatments anyone on this application takes or receives regularly and the condition for which he or she takes the medication:

Applicant Name	Medication/Treatment	Condition

37. List below all hospital admissions for you or anyone on this application within the past five years (including mental health or chemical/alcohol dependency). If none, please write Not Applicable.

Applicant Name	Date	Length of Stay	Reason	Result	Hospital

38. If you answered *Yes* to any medical questions, complete the chart below. Should you require more space to provide complete and accurate information, please attach a separate sheet of paper, sign and date the paper, and check this box: ☐

Question Number	Name of Individual	Medical Condition	Date of Onset	Still under treatment? Yes or date treatment ended	Treatments, advice, results, or other details	Name, address, and phone number of physician treating medical condition

PAYMENT ELECTION

39. I hereby authorize UPMC Health Plan, its affiliates, and subsidiaries to deduct insurance payments from my account at the financial institution named below.

I hereby authorize UPMC Health Plan, its affiliates, and subsidiaries to deduct insurance payments from my account at the financial institution named below.

Payer (if not the applicant)

Name

Street

City　　State　　ZIP

Payment Method (You must choose one.) ☐ Credit Card ☐ Checking/savings/share draft account PAC/EFT

Credit Card Options ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Account Number ______ Expiration Date: ______

ZIP code of credit card account holder (required for security purposes): ______ (This is the ZIP code where the payer receives the bill.)

Preauthorized Check or Electronic Funds Transfer Options

☐ Checking Account ☐ Savings Account ☐ Credit Union Share Draft Account

Banking or Financial Institution Name: ______

Routing Number ______ Account Number ______

This agreement is to remain in effect until UPMC Health Plan has received written and signed notification from me of its termination in such time and in such manner as to afford UPMC Health Plan and the depository institution a reasonable opportunity to act on the request.

UPMC Health Plan will notify me in advance whenever the deduction amount or deduction day changes via the monthly invoice. UPMC Health Plan may revise the terms of this agreement at any time upon written notification.

Signature of banking or credit card holder (as it appears on your account)　　Date

PERSONAL HEALTH INSURANCE STATEMENT

This insurance coverage is not designed nor marketed as employer-provided insurance. This coverage does not comply with all your state's small-employer group health insurance laws. Therefore, this plan cannot be used, now nor at some future date, by you or an employer to provide health insurance for employees. I agree that:

(a) I am not employed by an employer with 2-50 employees; or
(b) I am employed by an employer with 2-50 employees; however, no portion of the premium for this individual plan is paid, either directly or indirectly by my employer.

If you cannot agree to either (a) or (b) above, you are not eligible to apply for this plan.

I understand that my premium cannot be paid with an employer check unless I am agreeing under (a) above.

By checking below and signing this application, I agree that I understand that I am applying for personal health insurance that may never be used as employer-provided insurance

I have read the above Personal Health Insurance Statement. ☐ **Check here before going further.**

HEALTH INSURANCE AUTHORIZATION TO OBTAIN AND DISCLOSE NON-MEDICAL INFORMATION

I authorize UPMC Health Plan to obtain information needed to underwrite or verify my application for insurance. Any person, employer, insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having non-medical information about my family or me is authorized to give it to UPMC Health Plan.

UPMC Health Plan may also release this information about my family or me to the MIB or any member company for the purposes described in the UPMC Health Plan Notice of Privacy Practices.

I have read the above Health Insurance Authorization to Obtain and Disclose Non-Medical Information. ☐ **Check here before going further.**

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize, on behalf of myself, and eligible dependents and spouse, if any, UPMC Health Plan to obtain health information needed to underwrite or verify my application for insurance.

Any health care provider, the Medical Information Bureau (MIB), pharmacy benefit manager, pharmacy related service organization, or insurance company having any information as to a diagnosis, treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to UPMC Health Plan. This includes mental health, substance abuse treatment/conditions, and AIDS-related information.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

I further authorize the release by, to, or among the various UPMC Insurance Services Division entities for all lawful purposes, including, but not limited to, medical management and implementation of health/wellness initiatives.

UPMC Health Plan may release this information about my family or me to the MIB or any member company for the purposes described in UPMC Health Plan's Notice of Privacy Practices.

This authorization shall remain valid for 30 months from the date of signature on this application.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to UPMC Health Plan, as explained in UPMC Health Plan's Notice of Privacy Practices. UPMC Health Plan may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I understand I have the right to retain a copy of this authorization.

I have read the above Authorization to Obtain and Disclose Health Information. ☐ **Check here before going further.**

UPMC Health Plan's Privacy Statement and Notice of Privacy Practices may be reviewed at www.upmchealthplan.com or requested from UPMC Health Plan at 1-866-353-3598.

CHANGES TO YOUR CONDITION PRIOR TO EFFECTIVE DATE

Any change in medical condition, and any medical treatment or advice from a physician or provider, for you or anyone on this application, that occurs after you have submitted a signed application, must be immediately reported to UPMC Health Plan. Coverage may be denied or canceled, or premium increased based on those changes occurring in the period between the application signature and the policy/coverage between the application signature and the policy/coverage effective date. Send notification in writing to: Attention:Underwriting, UPMC Health Plan, 112 Washington Place, Pittsburgh, PA 15219.

STATEMENT OF UNDERSTANDING: Review the completed application and read the section below carefully before signing.

I have read this application or had it read to me. I represent that the answers and statements on this application are true, complete, and correctly recorded. Any person who knowingly and with 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 and agree that:** (1) this application and the payment of the initial premium do not give me immediate coverage; (2) incorrect or incomplete information on this application may result in voidance of coverage or claim denial; (3) this completed application, and any supplements or amendments, will be made a part of any policy or certificate which may be issued; (4) the insurance producer is only authorized to submit the application and initial premium, and may not change or waive any right or requirement; (5) continuation of other coverage existing on the UPMC Health Plan effective date for more than 90 days after the effective date will void this coverage; and (6**) providing false information or omission of relevant information in this application may result in the denial of claims or cancellation of coverage.**

A request for new insurance coverage will require me to submit a completed application. I understand that my application will be void after 60 days if it has not been completed and submitted for review.

Your signature in this space completes your authorization and your agreement to check boxes completed earlier in this application.

Signature of Primary Applicant (you) ____________________

Signature of Spouse (if to be covered) ____________________

Signature of Parent/Guardian (if you are a minor) ____________________ Relationship ____________________

Signed ____________ at ____________________
Date City State

Signature of Other Adult ____________________ Relationship ____________________

INSURANCE PRODUCER STATEMENT: Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has read or had read to him or her the completed application. The applicant is fully aware that any false statement or misrepresentation may result in voidance of coverage under the policy.

Signature of Insurance Producer ____________________

Print Full Name ____________________

Insurance Producer Number ____________________

If you have current insurance coverage and this policy will replace it, please complete this section.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by UPMC Health Benefits, Inc. Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions, which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force.

After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

This Notice to Applicant was delivered to me in the application on:

____
(Date)

____
Signature of Applicant