University of Pittsburgh

Office of Human Resources
Benefits Department

320 Craig Hall, Pittsburgh, PA 15260
Phone: 412-624-8160 | Fax: 412-624-3485
Email: hr-benque@pitt.edu | hr.pitt.edu/benefits

Temporary Employees: working an average of thirty (30) hours of service per week

| For HR Benefits Department Use Only | |
|---|---|
| Effective Date | Employee # |
| Processed By | Process Date |

## Pre-Tax Selections

Medical coverage and optional Health Savings Account (HSA) will be deducted on a pretax basis. This reduces the employee's federal income and social security taxes.

## Documentation and Required Information

All applicable documentation must be submitted to the Office of Human Resources Benefits Department with this enrollment form; otherwise, your election(s) will not be put into effect.

- If you are making an election to cover (for the first time) a spouse, domestic partner, and/or child(ren) with medical, dental, and/or vision coverage, documentation of the relationship is required.
  - For a spouse, present a copy of the marriage certificate.
  - For a domestic partner, please visit http://www.hr.pitt.edu/domesticpartner for the Affidavit of Domestic Partnership and requirements.
  - For dependent children, present a copy of the birth certificate(s). Paperwork for adopted children or stepchildren is also applicable.
- Social security numbers are required (if applicable) for dependents covered under the medical, dental, and/or vision coverage.
- If you are making a qualified status change, documentation is required. Please see http://www.hr.pitt.edu/benefits/qualified for examples.

## Employee Data

*Name (Last, First, M.I.)*

*Email (Preferred)*

## UPMC Medical Plan
***(Choose A & B or C)***

***(a) Choose your Medical Plan Option***

☐ Panther Basic (PPO) Qualified High Deductible Health Plan (QHDHP) with Optional Health Savings Account (HSA)

***(b) Choose your Level of Coverage***

☐ Individual ☐ Two Adults

☐ Parent/Child(ren) ☐ Family

***(c) Choose to Not Participate***

☐ Waive Medical Coverage

## Optional Health Savings Account (HSA)
***(Choose A to elect or B to waive)***

***(a) Choose to Participate****

☐ Health Savings Account (HSA)
Contribution per pay period $

*Individual Maximum: $3,400; Age 55+ increase $4,400.*
*Family Maximum: $6,750; Age 55+ increase $7,750.*

***(b) Choose to Not Participate***

☐ Waive Health Savings Account (HSA)

## Member Data

| Relationship | Last Name, First Name, M.I. | Social Security # | Date of Birth (mm/dd/yy) | Check Selection(s) | | | | | | Practice Code (4 Digits) Panther Gold HMO Only | Provider ID (9 Digits) Concordia Plus DHMO Only |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Medical | | Dental | | Vision | | | |
| | | | | ADD | WAIVE | ADD | WAIVE | ADD | WAIVE | | |
| **Self** Gender | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Spouse/Partner** Gender | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Child** Gender | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Child** Gender | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Child** Gender | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Child** Gender | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |

*If adding more than four children, check this box and continue on an additional signed form.* ☐

## Certification and Signature

I understand that:

- My benefit selections will remain in effect and may only be changed during the annual open enrollment period or due to a qualified status change permitted under the University of Pittsburgh Welfare Benefit Plan.
- If I check "Waive," I and/or eligible dependents will not be covered for any of the above benefit options.
- If I elect not to enroll in any University medical plans, I will not be eligible for a subsidy on the exchange and that I need to have proof of alternative medical coverage under another plan.
- If I withdraw from a plan during the open enrollment period or due to a qualified status change and request that my payroll deduction be cancelled accordingly, I relinquish my rights to coverage under the designated terms and conditions. If I desire to participate again, after withdrawal I may do so only at designated times.
- The University contribution for medical coverage includes a benefit credit and I authorize the University to adjust my pay accordingly through payroll deduction.
- If I have the right to recover expenses incurred for my own or my dependent's care from another person or organization that may have caused my own or my dependent's injury or illness, the University of Pittsburgh Welfare Benefit Plan has the right to recover the full amount it paid for my own or my dependent's care and that I have a legal obligation to help recover the amounts the Plan paid. The Plan reserves the right and is entitled to be repaid the entire amount of any amount awarded to me or my dependents, regardless of the amount of the award we actually receive.
- That the Plan may disclose my personal health information as described in the University of Pittsburgh's Notice of Privacy Practices.

I certify that all of the information provided above is true and correct and is being provided for the purpose of securing insurance benefits for me or other persons eligible under this insurance benefit program.

I further acknowledge that it is unlawful for any person to make a false or inaccurate statement for the purpose of acquiring insurance benefits for themselves or any other person, and further acknowledge and agree that any false or misleading statement herein may affect eligibility for benefits and may result in discipline by the University of Pittsburgh (up to and including termination of employment) to the extent otherwise permitted by law.

*Signature* *Date*

*Forms are only accepted via fax (412-624-3485), mail or in-person drop off. Forms are NOT accepted via e-mail because of the University's security policy on the transmission of personal information.*

Print Form