

2020-2021 Health Insurance Enrollment Form — Students

Robert Morris University requires that you have adequate health insurance while you are enrolled as a student. If you lose your current coverage while you are a student, you may be eligible to enroll in our Student Health Insurance offered through UPMC Health Plan. In order to enroll, please complete and return this enrollment form at your earliest convenience. In addition to this application, please provide a copy of your proof of loss coverage provided by your previous carrier.

To enroll by fax, send forms to:

Attn: Cut Log#
412-454-8519

Contact Information

Student name (First, MI, Last): _____ Student email: _____

Student cell phone #: _____ Alternative phone #: _____

Emergency contact name: _____ Emergency contact phone #: _____ Relationship: _____

Emergency contact location (City/State/Country): _____

Emergency contact speaks English: Yes No If no, primary language: _____

Enrollment

Plan Year: August 1, 2020, through July 31, 2021

YES _____ (initial here) I accept the Robert Morris University-sponsored UPMC Health Plan Individual Health Insurance Plan.

Required Information: (Insurance ID cards will be mailed to this address)

Student name (First, MI, Last): _____ Social Security number: _____ - _____ - _____

Address 1: _____ Address 2: _____

City: _____ State: _____ ZIP: _____ Date of birth: ____/____/____ Gender (circle): Male or Female

Payment

Coverage: _____ Date previous coverage terminated: _____

Effective date for this policy: _____ (there cannot be a lapse in coverage)

Premium: (_____) Total # of months being purchased
x \$167.57 Monthly Premium (current month through July 31, 2021)
= _____ Total Premium Due

Premiums will be remitted by: MasterCard or Visa credit card #: _____ Exp. date: _____ Security code: _____

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.

Signature: _____ **Date:** _____



Nondiscrimination Notice

UPMC Health Plan¹ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UPMC Health Plan:

• Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Civil Rights Administrator.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Administrator
UPMC Health Plan
600 Grant Street - 55th Floor
Pittsburgh, PA 15219

Phone: 1-844-755-5611 (TTY: 1-800-361-2629)
Fax: 1-412-454-5964
Email: HealthPlanCompliance@upmc.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Administrator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

¹UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-420-9589 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-420-9589 (TTY：1-800-361-2629)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-420-9589 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-420-9589 (телетайп: 1-800-361-2629).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call 1-866-420-9589 (TTY: 1-800-361-2629).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-420-9589 (TTY: 1-800-361-2629)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-420-9589 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 9589-420-866-1 (رقم هاتف الصم والبكم: 1-800-361-2629).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-420-9589 (ATS : 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-420-9589 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-420-9589 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-420-9589 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-420-9589 (TTY: 1-800-361-2629).

ប្រយ័ត្ន: បើនិយាយភាសាខ្មែរ, សេវាជំនួយភាសា ដោយឥតគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ជូរ ទូរស័ព្ទ 1-866-420-9589 (TTY: 1-800-361-2629)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-420-9589 (TTY: 1-800-361-2629).