Open Enrollment Verification!

**Your response is required.** Failure to provide the information below may delay the processing of your medical claims. We are collecting the following information to verify if you or your dependents have any other medical coverage. Please respond even if you have no other insurance.

**Other Insurance**
1) Do you or your family members have other medical insurance coverage with another company, or through Medicare?

☐ No  ☐ Yes

*If you answered ‘no,’ you may skip questions two & three, then fax or mail this form to the number/address below.*

If you answered ‘yes’ to the above question, please continue below.

2) If you and/or your covered dependent(s) have medical insurance coverage with another company, or through Medicare, please complete the following information.

Name(s) of member(s) with other insurance coverage: ____________________________

Planholder/Insurance Company Name: ____________________________

Medical Plan Number: _______________ Coverage Type: ☐ Family  ☐ Single

Medicare HIC Number: _______________

3) If any of your dependents have court-ordered medical coverage, please return this form with the medical coverage section of your Court Decree.

**Please update the other insurance information by doing one of the following:**

- Call 866-586-0613 and enter this information in the automated system
- Visit umr.com, log into your account and click the appropriate response under the tile marked ‘OTHER INSURANCE’
- Complete this form and mail to UMR, PO Box 30541, Salt Lake City, UT 84130-0541
- Fax the completed form to (877) 293-4926

Failure to complete and return this form, or utilize one of the other reporting methods above may delay payment of your claims.

I hereby certify all information given by me is accurate and true.

Print Employee Name ____________________________ Employee Signature ____________________________

Date ____________________________

Member ID # _______________