Clark County
Exclusive Provider Organization

UMR

SELF-FUNDED GROUP MEDICAL and DENTAL BENEFITS PLAN
Clark County

IMPORTANT HEALTH INSURANCE INFORMATION - PLEASE SEND UPDATE BACK WITHIN 31 DAYS

Name:_____
Address:_____
Phone:_____
Member ID #:_____
GROUP: CLARK COUNTY

UMR is requesting up-to-date information regarding any additional health care coverage that you or your covered spouse or dependent children may have obtained. We must have your reply *annually* to avoid delays in the processing of claims.

Please fill out this questionnaire completely and return to UMR:

1) Is anyone in your family covered by another medical or dental plan? Yes ☐ No ☐
(Examples: A stepchild covered by a natural parent; a child covered by another parent through divorce decree; an adult dependent covered by his/her own employer or his or her spouse's employer, or continued coverage for a spouse after termination of employment.)

If yes, provide the following:

Dependent name_____Relationship_____
Dependent name_____Relationship_____
Dependent name_____Relationship_____
Dependent name_____Relationship _____

Name of Health Plan / Policy holder name, relationship and **Date of Birth**/ Member # / Group # / Effective date / Phone #

_____
_____
_____

Is there a divorce decree or legal documentation indicating who is to cover dependent? Yes ☐ No ☐
If yes, please submit a copy along with this completed notice.

2) Is anyone in your family covered by Medicare?

Part A Yes ☐ No ☐
Part B Yes ☐ No ☐
Part C Yes ☐ No ☐

List family members, if covered by Medicare _____

(Please note: If you are a Retiree and eligible for Medicare, you must maintain your Medicare B coverage for both retiree and dependents as penalties may apply)

Medicare ID Number and effective date: _____

What is the reason for Medicare Eligibility? Please check one – Age ☐ Disability ☐ ESRD ☐ Other _____

I certify and affirm that my dependents listed above is an eligible dependent pursuant to the provisions and requirements as outlined in the Clark County benefits Plan eligibility requirements and coordination of benefits. I attest under penalty of perjury this information is true to the best of my knowledge as of the date of my signature hereon and I further acknowledge that I must notify my employer within 31 days of any change in this eligibility or coverage.

I understand and acknowledge that in the event such information is untrue or inaccurate or I fail to remove a dependent from my chosen health plan within 31 days from the date that they no longer qualify as a dependent pursuant to the provisions and requirements of coverage, then this fraud may subject me to a variety of consequences including but not limited to, referral to the District Attorney's Office for criminal prosecution, restitution to the Plan for improperly medical/dental/pharmacy paid claims and premiums, referral to my employer for disciplinary action up to and including termination and termination of my health coverage.

Employee signature only:_____ Date:_____

Please return to UMR at PO Box 30541, Salt Lake City, UT 84130-0541. You may also E-Mail this notice to clarkcountycobupdate@umr.com or fax to UMR at 915-581-7537