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

Name: _____
Address: _____
Phone: _____
Member ID #: _____
GROUP: CLARK COUNTY SELF-FUNDED MEDICAL AND DENTAL PLAN

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.

Effective 1/1/2004, the Clark County Self-Funded Group Medical and Dental Benefits Plan (CCSF) requires dependent spouses when covered under CCSF, to enroll in their own employer-sponsored program, if available.

Clark County Self-Funded Group Medical and Dental Benefits Plan Document under Dependent Eligibility states:

Requirement for spousal enrollment in other group insurance. If a spouse is covered as a dependent of an employee or retiree covered by the Clark County Self-Funded Health Benefits Plan, and the spouse is employed by a company that offers an employee health benefit plan (Medical/Dental), or a retiree benefit plan as a retiree of another company, and he/she is eligible for such (non-HMO) coverage at a monthly cost of $105.00 or less for employee only, the spouse is required to enroll in such other employer-sponsored program. If the spouse declines any other employer-sponsored coverage, Clark County Self-Funded Health Benefits Plan will provide coverage to the spouse at 20% of the Plan allowable, instead of the normal benefit payable for such services covered by the Clark County Self-Funded Health Plan. When the penalty is imposed, there will be no prescription coverage as the Clark County Self-Funded Plan, does not coordinate prescription benefits.

Please fill out this questionnaire completely and return to UMR:

Bi-weekly or 26 Payroll periods (most common)
Rate X 26 Payrolls = Yearly Rate Yearly Rate/12 = Monthly rate
Bi-monthly or 24 Payroll periods
Rate X 24 Payrolls = Yearly Rate Yearly Rate/12 = Monthly rate
Weekly Payroll
Rate X 52 Payrolls = Yearly Rate Yearly Rate/12 = Monthly rate
Yearly rate
Divide by 12

Spouse's Name: _____

1. Is your Spouse Employed? Yes ☐ No ☐ Self Employed ☐
2. Name of employer _____
3. Employer address _____
4. Employer telephone number _____
5. Is your spouse offered health and/or dental insurance coverage? Yes ☐ No ☐
6. Insurance monthly premium for employee only, lowest cost*non-HMO Plan** available for medical + dental $_____ (*see payroll table*)
7. Insurance rate sheet attached Yes ☐ No ☐
8. Was employer sponsored coverage elected? Yes ☐ No ☐
9. Insurance plan information, if applicable:
   Effective date of coverage: _____ Policy number: _____
   Name of insurance company: _____
   Address/Phone of insurance company: _____

**Includes discounts for wellness participation programs and non-smoker rates*
***Non-HMO Plans may include PPO, POS, EPO, HDHP, HRA, HSA or Minimum Essential Plans*

I certify and affirm that my spouse listed above is an eligible dependent pursuant to the provisions and requirements as outlined in the Clark County Self-Funded Group Medical and Dental Benefits Plan as revised 08-18, pages 6-8 Eligibility Provisions – Dependent Eligibility. I further certify that my spouse is not offered an (non-HMO) employer sponsored health plan insurance or a retiree benefit plan for $105 dollars a month or less. 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 31days** of any change in this eligibility.

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: _____

Continued on the reverse side of this notice

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Dependent verification of other insurance coverage:

1) Is anyone in your family covered by Medicare? Part A: Yes ☐ No ☐
Part B: Yes ☐ No ☐
Part C: Yes ☐ No ☐

List family members 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 located on Medicare ID card: _____

Medicare effective date: _____

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

2) Other than identified above, 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 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.

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.

Employee signature only: _____ Date:_____

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