Employee Questionnaire

Employer:
Group Number:

Welcome to UMR!

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 health 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 'yes' to the above question please continue with additional questions. If you answered 'no' you may skip questions two and three.

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 with other insurance coverage:_____

Planholder/Insurance Company Name:_____

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

Medicare HIC Number : _____

3) If any of your dependants have court ordered medical coverage please returns this form with the medical coverage section of your Court Decree.

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

- ❑ Call the number on your ID card to speak with a representative
- ❑ Visit umr.com
- ❑ 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 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 #

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