

Employee Questionnaire

**Employer: Garrett County Employees Health Care Plan
Group Number: 76-411761**

Welcome to UMR!

In an effort to help your employer offset rising health care costs, we are collecting the following information to verify whether you or your dependents have any other medical coverage. Please respond even if you have no other insurance. **Your response is required.** Failure to provide the information below by **July 1, 2017**, may delay the processing of your medical claims.

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 #2 and #3.

- 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 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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