Group: 76-412150

CEBT Other Insurance Questionnaire

Enrollee Name: _____ *Member ID Number:* _____

Providing other insurance information to UMR before a claim is submitted will allow your claims to be processed more quickly. Once our records have been updated, UMR will only request the information annually, unless there is a change in the information.

Other Insurance Information

Do you or any covered family participants have coverage other than your CEBT coverage?

Medical ☐ YES ☐ NO Vision ☐ YES ☐ NO

If yes to any of the above, please provide information about the other coverage:

Insurance Company Name: _____

Type of Coverage: Medical Y / N Vision Y / N

Telephone Number (____) ____-_____ Policy or Group Number _____

Effective Date of Coverage: ___/___/_____

Please provide information about the person who carries other coverage:

Name: _____ Date of Birth ___/___/_____

Social Security or ID Number: _____ Relationship to: _____

If other coverage is provided by an Employer Plan, please provide the Employee Name:

_____ Employee Actively at Work? ☐ YES ☐ NO

If the above coverage is Medicare, please indicate the type of coverage:

____ Part A (Inpatient Hospital) Effective Date ___/___/_____

____ Part B (Outpatient/Medical) Effective Date ___/___/_____

Names and effective dates of coverage for each dependent (if any) covered by plan described above:

Full Name	Effective Date of Coverage
_____	___/___/_____
_____	___/___/_____
_____	___/___/_____

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

I certify that the above information is true and complete.

Signature of Enrollee _____ Date _____

Day Time Telephone Number (if additional information is needed) (____) ____-_____

Please return the completed form to:

Fax (877) 293-4926 Or Mail to: UMR
PO BOX 30541
Salt Lake City, UT 84130-0541


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BENEFIT
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TRUST