INSURANCE CREDIT REQUEST

Attached is the Insurance Premium Credit Request form. Complete the form, attach proof of the monthly insurance premium amount paid by the employee, (copy of check stub, statement from employer, etc.), names of all individuals covered by the policy (statement from your insurance company or copy of insurance policy showing all individuals covered on policy) and return the form to the Office of Recovery Services (ORS) at the address below.

In accordance with Utah Administrative Rule 527-201-7(3), if an insurance credit is applicable, it will be applied ". . . beginning the first day of the month following the date ORS/CSS receives the completed Insurance Premium Credit Request letter." Pursuant to R527-201-7(4), verification of the coverage and costs is required by ORS.

Utah Code 81-6-208(10)(a) requires "[t]he parent maintaining health care coverage or insurance shall provide verification of coverage to the other parent, or to the office . . . upon initial enrollment of the child, and after initial enrollment on or before January 2 of each calendar year." Utah Code 81-6-208(10)(b) provides that "[t]he parent shall notify the other parent, or the office. . . of any change of insurance carrier, premium, or benefits within 30 calendar days of the date the parent first knew or should have known of the change." Failure to comply with these requirements may result in denial of the insurance credit pursuant to Utah Code 81-6-208(10)(d).

If you have questions regarding this matter, please call ORS at (801)536-8500.

Send all documentation and correspondence to the following address:

Office of Recovery Services
PO Box 45033
Salt Lake City, UT 84145-0033

Attachment

Your Full Name:
Your ORS Case No.:

INSURANCE PREMIUM CREDIT REQUEST

In order to process an insurance credit request, ORS must receive your completed Insurance Premium Credit Request form including **proof of the insurance premium amounts paid and verification of coverage documenting all individuals covered under the policy**. If the form is incomplete or the required verification is not provided with the submitted request, you may not receive an insurance credit.

MEDICAL INSURANCE POLICY:

Policyholder Name: _____ Policyholder Date of Birth: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

City: _____ State: _____ ZIP: _____

Insurance Company Phone: _____ BCBS Code: _____

Premium Amount: _____ Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly

Monthly Cost to Policyholder to Insure: Self: _____ Double: _____ Family: _____

Does coverage extend to dependents loving outside the state where Policyholder resides? ☐ Yes ☐ No

List the name of each person covered on the policy and the relationship to the Policyholder:

NAME	RELATIONSHIP	NAME	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional types of coverage included in Medical insurance Policy: ☐ Dental ☐ Vision ☐ Pharmacy

DENTAL INSURANCE POLICY:

Policyholder Name: _____ Policyholder Date of Birth: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

City: _____ State: _____ ZIP: _____

Insurance Company Phone: _____ BCBS Code: _____

Premium Amount: _____ Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly

Monthly Cost to Policyholder to Insure: Self: _____ Double: _____ Family: _____

Does coverage extend to dependents loving outside the state where Policyholder resides? ☐ Yes ☐ No

List the name of each person covered on the policy and the relationship to the Policyholder:

NAME	RELATIONSHIP	NAME	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional types of coverage included in Medical insurance Policy: ☐ Dental ☐ Vision ☐ Pharmacy

VISION INSURANCE POLICY:

Policyholder Name: _____ Policyholder Date of Birth: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

City: _____ State: _____ ZIP: _____

Insurance Company Phone: _____ BCBS Code: _____

Premium Amount: _____ Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly

Monthly Cost to Policyholder to Insure: Self: _____ Double: _____ Family: _____

Does coverage extend to dependents loving outside the state where Policyholder resides? ☐ Yes ☐ No

List the name of each person covered on the policy and the relationship to the Policyholder:

NAME	RELATIONSHIP	NAME	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional types of coverage included in Medical insurance Policy: ☐ Dental ☐ Vision ☐ Pharmacy

PHARMACY INSURANCE POLICY:

Policyholder Name: _____ Policyholder Date of Birth: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

City: _____ State: _____ ZIP: _____

Insurance Company Phone: _____ BCBS Code: _____

Premium Amount: _____ Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly

Monthly Cost to Policyholder to Insure: Self: _____ Double: _____ Family: _____

Does coverage extend to dependents loving outside the state where Policyholder resides? ☐ Yes ☐ No

List the name of each person covered on the policy and the relationship to the Policyholder:

NAME	RELATIONSHIP	NAME	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional types of coverage included in Medical insurance Policy: ☐ Dental ☐ Vision ☐ Pharmacy

Printed Name: _____ Phone Number: _____

Signature (required): _____ Date: _____

Send all documentation and correspondence to the following address:

Office of Recovery Services
PO Box 45033
Salt Lake City, UT 84145-0033