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 527-201-8(2), if an insurance credit is applicable, it will be applied “... beginning the first of the month following the date ORS/CSS receives the completed Insurance Premium Credit Request ...” and the required verification of the coverage and costs.

U.C.A. 78B-12-212(8) requires parents ordered to maintain insurance coverage for their minor child(ren) to notify and provide verification of that coverage to ORS "... upon initial enrollment of the dependent child, and after initial enrollment on or before January 2 of each calendar year." Also per U.C.A. 78B-12-212(8), changes to insurance carrier, premium paid, or benefits must be reported to the office "... 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 U.C.A. 78B-12-212(10).

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
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: ______________________________________

Insurance Company City: ___________________________ State: __________ ZIP: ______
Insurance Company Phone: ___________________________ Date Coverage Began: __________________
Policy Number: ___________________________ BCBS Code: ________________
Premium Amount: ___________________________
Frequency: ☐ Weekly  ☐ Biweekly  ☐ Semi-monthly  ☐ Monthly
Monthly Cost to Policyholder to Insure: Self: __________ Double: _________ Family: __________
Does coverage extend to dependents living outside of the state where Policyholder resides? ☐ Yes ☐ No
List the name of each person covered on the policy and the relationship to the Policyholder:

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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: ______________________________________

Insurance Company City: ___________________________ State: __________ ZIP: ______
Insurance Company Phone: ___________________________ Date Coverage Began: __________________
Policy Number: ___________________________ BCBS Code: ________________
Premium Amount: ___________________________
Frequency: ☐ Weekly  ☐ Biweekly  ☐ Semi-monthly  ☐ Monthly
Monthly Cost to Policyholder to Insure: Self: __________ Double: _________ Family: __________
Does coverage extend to dependents living outside of the state where Policyholder resides? ☐ Yes ☐ No
List the name of each person covered on the policy and the relationship to the Policyholder:
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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: ____________________________________________________
Insurance Company Phone: _____________________________________________________
Date Coverage Began: _________________________________________________________
Policy Number: ___________________________ BCBS Code: ___________________________
Premium Amount: ___________________________
Frequency: □ Weekly □ Biweekly □ Semi-monthly □ Monthly
Monthly Cost to Policyholder to Insure: Self: __________________ Double: __________ Family: __________
Does coverage extend to dependents living outside of the state where Policyholder resides? □ Yes □ No
List the name of each person covered on the policy and the relationship to the Policyholder:
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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: ____________________________________________________
Insurance Company Phone: _____________________________________________________
Date Coverage Began: _________________________________________________________
Policy Number: ___________________________ BCBS Code: ___________________________
Premium Amount: ___________________________
Frequency: □ Weekly □ Biweekly □ Semi-monthly □ Monthly
Monthly Cost to Policyholder to Insure: Self: __________________ Double: __________ Family: __________
Does coverage extend to dependents living outside of the state where Policyholder resides? □ Yes □ No
List the name of each person covered on the policy and the relationship to the Policyholder:
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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