

Thank you for making University of Utah Health Plans your choice for health care coverage.

University of Utah Health Plans is committed to providing great customer service. Because insurance information is constantly changing we need your help to make sure our records are accurate and up to date.

If you or your dependent(s) have other health insurance, in addition to University of Utah Health Plans coverage, please complete this form.

This information allows us to accurately process your health care bills. For your convenience we have included a postage paid envelope addressed to us at: University Health Plans, PO Box 45180, Salt Lake City UT 84145.

If you have any questions please call Member Services: (801)587-6480 or (888)271-5870.

University of Utah Health Plans – Name: _____ Subscriber ID#: _____

Other Health Insurance Information

Member Name	Policy Holder Name	Policy Holder Date of Birth	Member Relation to Policy Holder	Policy Number	Insurance Company	Primary or Secondary	Original Effective Date of Policy

Important Instructions

Medical / Mental Health / Pharmacy Insurance: Complete and return this form only if you or your dependent(s) have other Medical, Mental Health or Pharmacy Insurance in addition to University of Utah Health Plans coverage.

Dental Insurance: This form does not apply to Dental Insurance. If you or your dependent(s) have other Dental coverage, it is not necessary to list it on this form.

No Other Insurance: Disregard this form if you and/or your dependent(s) have no other Medical or Mental Health Insurance coverage in addition to University of Utah Health Plans coverage.