



CERTIFICATION OF DUAL UNIVERSITY COVERAGE FOR COORDINATION OF PRESCRIPTION BENEFITS

Coordination of Prescription Drug Benefits with a \$0 coinsurance amount at the pharmacy is ONLY available when all family members are covered by both employees. If some family members are only covered by one employee, you may be required to pay a coinsurance amount at the pharmacy and submit a paper claim to Caremark for reimbursement.

Employee Information	
HUSBAND	WIFE
Name: _____	Name: _____
Employee ID No.: _____	Employee ID No.: _____
Daytime Phone: _____	Daytime Phone: _____

Eligible Dependent Children Enrolled in the Health Plan		
Name	Covered by Husband	Covered by Wife
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Certification	
We each hereby certify the following:	
<ul style="list-style-type: none"> ❖ I am enrolled in the University of Utah Employee Health Care Plan and have enrolled my spouse and the listed dependent children as dependents on my coverage. ❖ I acknowledge that I, my spouse, and any listed dependent children are only eligible for coordination of prescription drug benefits for as long as my spouse and I each maintain coverage through the University and cover the other and any listed dependent children. ❖ In the event I terminate my coverage, I will contact the University Benefits Department and notify them of the cancellation. ❖ In the event I utilize coordination of prescription drug benefits while I am not eligible, I will refund any amounts overpaid by the health plan. ❖ All the information entered on this form is true and correct. I acknowledge that using this benefit improperly or knowingly providing a statement that contains any false, incomplete or misleading information may result in both adverse employment action, up to and including termination of employment, and adverse tax consequences, including penalties and interest. 	
_____ Husband Date: _____	_____ Wife Date: _____

Submit Completed Forms To:	
Benefits Department 420 Wakara Way, Ste. 105 Salt Lake City, UT 84108	Phone: 581-7447 Fax: 585-7375 Email: benefits@hr.utah.edu