



c/o PDA – Verification Team
17199 N. Laurel Park Drive, Suite 400
Livonia, MI 48152

SPOUSAL VERIFICATION FOR HEALTH BENEFIT COVERAGE
RESPONSE REQUIRED BY 02/20/2024
PLEASE SEE REVERSE SIDE

January 30, 2024

[«IdnEmployeeID»]
«Emp_FN» «Emp_LN»
«Emp_Addr1» «Emp_Addr2»
«Emp_City», «Emp_State» «Emp_Zip»

Dear Member:

The University of Arkansas is partnering with **Part D Advisors (PDA)**, a third-party service provider specializing in health benefit coverage reviews, to conduct a spousal eligibility verification of our health benefits. The purpose of the verification is twofold: to confirm that all enrolled spouses meet the UAS health benefits eligibility rules and to update your contact information.

For this verification, you will need to do the following:

- Step 1. **Review your address and date of birth for accuracy.** If you find errors, please print the correct information in the Step 1 box on the back of this letter.
- Step 2. **Confirm that your listed spouse is eligible to be covered under the university health plan and provide a copy of your 2023 or 2022 filed Form 1040 federal income tax return.** The eligibility requirements are printed on the back of this form.
- If your spouse meets the requirements, they can remain on the university health plan if you complete and return this form with the appropriate documentation.
 - If your spouse does **not** meet the requirements, please check the “Remove from Coverage” box located to the left of your spouse’s name found in Step 2 on the back of this form. Your spouse will be removed from coverage on the date they are determined to be ineligible.
- Step 3. **Update your contact information in Step 3 on the back of this form.**
- Step 4. **Sign and return the verification form with the supporting documents by 02/20/2024.**

You can complete your response with a smartphone or computer by **using our secure web portal to upload images of your supporting documents and providing an electronic signature at pdarev.com**. Registering for the web portal will also provide you with verification updates and confirmation notifications throughout the process. You will need the following information to log in to our secure website:

- **[Employee ID]:** Member ID (8-digit number located on your UMR medical plan card)
- **[Verification PIN]:** «VerCode»

Alternatively, you can complete your response by using the enclosed postage-paid envelope and mailing your signed form with photocopies (originals will not be returned) of your supporting documents to:

PDA – Verification Team, 17199 N. Laurel Park Drive, Suite 400, Livonia, MI 48152

To avoid a possible lapse in coverage for your spouse, you must provide the required documentation by 02/20/2024.

If you have any questions regarding this process, please call the PDA Verification Team at (833) 902-4808 between 8 a.m. and 4 p.m. CT, Monday through Friday. Any information you provide in response to this verification will be kept strictly confidential.

Thank you for your participation in this important process.

Office Code: «IdnFormLongID»

STEP 1: Review your personal information. Please print updates in the box below.

Employee/Retiree Information	[«IdnEmployeeID»]
«Emp_FN» «Emp_LN» «Emp_Addr1» «Emp_Addr2» · «Emp_City», «Emp_State» «Emp_Zip» Date of Birth: «Emp_DOB»	

STEP 2: Review your spouse’s information and the eligibility requirements chart. Submit a photocopy of the required verification document listed below in the chart. If your spouse is no longer eligible, please check the “Remove from Coverage” box. Complete eligibility guidelines are available in the health plan SPD at <https://benefits.uasys.edu/>

Remove from Coverage	Spouse First Name	Spouse Last Name
<input type="checkbox"/>	«Spouse_FN»	«Spouse_LN»

Relationship	Eligibility Requirements	Documentation to Submit*
Legal Spouse	Lawful spouse of the employee/retiree Important: If you are divorced, your former spouse is ineligible for coverage.	Copy of 2023 or 2022 filed federal income tax return Form 1040 - first page only (social security numbers and financial information may be redacted) *If you have any questions regarding supporting documents please call (833) 902-4808

STEP 3: Update your contact information.

Home Phone	Cell Phone	Work Email Address	Personal Email Address
«Emp_PhoneHome»	«Emp_PhoneCell»	«Email»	«email2»

STEP 4: Review and sign the following terms. Signing below indicates consent.

I confirm that the individual listed as my spouse on this form meets the eligibility requirements to be covered under the University of Arkansas health plan. In addition, I confirm that the documentation I have submitted as confirmation of dependent eligibility are true and valid documents that accurately reflect my relationship to my spouse. I understand that only eligible subscribers and their eligible dependents can participate in the Plan. Falsification of eligibility is a serious offense and may lead to disciplinary action up to and including termination of coverage for benefits and termination of employment. And I understand that the plan has the right to request reimbursement of premiums and claims paid for ineligible participants.

X

Signature

Date Signed

Office Code: «IdnFormLongID»