SelectHealth, Inc.
P.O. Box 30192
Salt Lake City, UT 84130-0192
800-538-5038
selecthealth.org

Dependent Address Change Form

(for members who get insurance through their employer)

Use this form when your Dependent moves out of your Service Area or to report if your Dependent has moved back inside the Service Area. After completing this form, please send it to SelectHealth Enrollment by email (**SHLEENR@selecthealth.org**) or by fax (**385-297-2064**). For more information about your Service Area, refer to your plan materials or contact Member Services.

Employee Name ______________________________ Date of Birth ______________

Subscriber# ______________________________ Social Security# ______________

A. DEPENDENT INFORMATION CHANGE

Dependent's New Address and Phone

Name (first, middle, last) ______________________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

Dependent's New Address and Phone

Name (first, middle, last) ______________________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

Dependent's New Address and Phone

Name (first, middle, last) ______________________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

Dependent's New Address and Phone

Name (first, middle, last) ______________________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

*Federal law section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 requires SelectHealth to gather this information.

C. EMPLOYEE SIGNATURE

I wish to change my Dependent's address as indicated above.

Employee Signature ______________________________ Date ______________

D. EMPLOYER USE

Employer Authorization ______________________________ Date ______________

Company Name ______________________________ Group # ______________

Comments ______________________________