

FEHB Dependent Address Change Form

(for members enrolled in the FEHB High Deductible Health Plan (HDHP) option)

If you are enrolled in the SelectHealth FEHB HDHP Option, use this form when your dependent* child moves outside of the SelectHealth FEHB service area (Utah) or to report that your dependent has moved back inside the service area. SelectHealth* offers participating benefits for covered services to enrolled dependent children who reside and receive services outside our service area. To qualify your out-of-area dependent for participating benefits, complete this form and send it to SelectHealth Enrollment by email (**FEHBEnroll@imail.org**) or by fax (**801-442-9873**). For more information about the service area, refer to your plan materials or contact Member Services at **844-345-FEHB**.

Federal Employee/Annuitant Name _____ Date of Birth (MM/DD/YY) _____

Subscriber ID # (found on your SelectHealth ID card) _____ Social Security #** _____ (Required)

Phone #(_____) _____ Street Address _____

City _____ State _____ ZIP _____

*Federal employees, annuitants, and spousal dependents are not eligible for this extended out-of-area coverage

A. DEPENDENT INFORMATION CHANGE

Dependent's New Address

Name (first, middle, last) _____ Sex (M/F) _____

Date of Birth (MM/DD/YY) _____ Date of Address Change (MM/DD/YY) _____

New Street Address _____ City _____

Social Security #** _____ State _____ ZIP _____ Phone #(_____) _____ (Required)

Dependent's New Address

Name (first, middle, last) _____ Sex (M/F) _____

Date of Birth (MM/DD/YY) _____ Date of Address Change (MM/DD/YY) _____

New Street Address _____ City _____

Social Security #** _____ State _____ ZIP _____ Phone #(_____) _____ (Required)

Dependent's New Address

Name (first, middle, last) _____ Sex (M/F) _____

Date of Birth (MM/DD/YY) _____ Date of Address Change (MM/DD/YY) _____

New Street Address _____ City _____

Social Security #** _____ State _____ ZIP _____ Phone #(_____) _____ (Required)

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

B. FEDERAL EMPLOYEE/ANNUITANT SIGNATURE

I wish to change my dependent's address as indicated above. To receive participating benefits, my dependent will need to receive care from providers on the appropriate local networks (as indicated on my SelectHealth ID card) when outside of the plan's service area.

Federal Employee/Annuitant Signature _____ Date (MM/DD/YY) _____

SelectHealth obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電

SelectHealth: **844-345-3342**