SelectHealth, Inc.
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selecthealth.

Change Form - Group

Employee Name ______________________ Date of Birth ______________

Subscriber # ______________________ Social Security # ______________

A. EMPLOYEE INFORMATION CHANGE

New Street Address ______________ City ______________ State ________ ZIP ________

New Ph #(______) ______________ Email Address ______________

Name Changed From ______________ to New Name ______________ ❑ Marriage ❑ Divorce

B. ADDITION OR DELETION OF FAMILY MEMBERS

	CHANGE	PLAN	NAME (LAST, FIRST, MIDDLE INITIAL)	SEX M/F	DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER *	REASON	
Spouse	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change ______________ ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage	❑ Marriage ❑ Divorce[1] ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change ______________ ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage	❑ Marriage ❑ Newborn ❑ Adoption ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change ______________ ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage	❑ Marriage ❑ Newborn ❑ Adoption ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change ______________ ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage	❑ Marriage ❑ Newborn ❑ Adoption ❑ Death

NOTES: You must give proof of prior coverage to SelectHealth within 60 days.

1. If you are making a change because of a divorce, your spouse must sign below or you must attach a copy of the divorce decree with this Change Form. You should include the first page of the decree, the signature page, and any other portion(s) that specifies responsibility for dependent coverage.

By signing this form, I acknolwledge that I will no longer have healthcare coverage through SelectHealth. I understand that I may have rights to contiue coverage as the result of my recent divorce and that additional information regarding how to continue coverage may be obtained through the Plan sponsor (spouse's employer).

Spouse's Signature ______________________ Date ____________

2. If you are adding a dependent because of a court or administrative order, please attach a copy with this form.
3. If you are making a change because of a loss of other coverage, please attach proof of prior coverage.

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

C. DISCONTINUANCE OF BENEFITS

I wish to discontinue benefits for myself and all my dependents. Check all that apply: ❑ Medical ❑ Dental ❑ Eyewear ❑ HSA

Reason for Discontinuance ______________________ Date of Discontinuance ____________

D. EMPLOYEE SIGNATURE

By signing, I agree to the changes requested above.

Employee Signature ______________________ Date ____________

E. EMPLOYER USE

Company Name ______________________ Group# ____________

Comments ____

I certify that the individual listed on this form is eligible for:

❑ COBRA

❑ mini-COBRA (applicable if you employed fewer than 20 employees on a typical business day during the preceding calendar year)

Employees applying for COBRA must complete a separate COBRA form

Date of Termination ______________________

Term Reason: ❑ Voluntary ❑ Part Time ❑ Employment Termination

Leave of Absence

❑ Leaving for Active Military Service ______________

Coverage to Remain Active ❑ Yes ❑ No

❑ Taking a Leave of Absence Date ________ Expected Return Date ________

Coverage to Remain Active ❑ Yes ❑ No

❑ Return from a Leave of Absence/Military Service

Date ______________________

Employer Signature ______________________ Date ____________

After completing this form, return by faxing to 385-297-2064