Fair Treatment Notice

SelectHealth complies with Federal civil rights laws. We do not discriminate or treat you differently because of your race, color, national origin, age, disability, or sex.

We provide free:

- Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at **1-800-538-5038** (TTY Users: 711)

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **1-800-538-5038**.

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: **1-800-538-5038**. 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **1-800-538-5038**.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **1-800-538-5038**.

번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́'', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih SelectHealth: **1-800-538-5038**.

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नम्तिि भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم SelectHealth: **1-800-538-5038**.

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សូវៅជំនួយផ្នែកភាសា ដាយមិនគិតថ្លៃ គឺអាចមានសំរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **1-800-538-5038** ។

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**. まで、お電話にてご連絡ください。

selecthealth.

SelectHealth, Inc.
P.O. Box 30192
Salt Lake City, UT 84130-0192
800-538-5038/Fax 801-442-5798
selecthealth.org

selecthealth.

Individual Plans Idaho Change Form

SEE REVERSE SIDE OF FORM FOR INSTRUCTIONS.

Note: *For plans purchased through Your Health Idaho—Idaho's Health Insurance Exchange—all requested changes and terminations MUST be processed through the exchange. Visit* ***yourhealthidaho.org*** *or call* ***855-944-3246****.*

A. SUBSCRIBER INFORMATION

Subscriber's Name _____ Subscriber ID# _____ (LOCATED ON ID CARD) Date of Birth _____

B. SUBSCRIBER INFORMATION CHANGES

Name Changed from _____ Marital Status Change ❑ Legally Married ❑ Divorced ❑ Deceased

Name Changed to _____ Effective Date of Marital Status Change _____

New Physical Address _____

New Mailing Address _____

City _____ State _____ ZIP _____ New Ph# (_____)_____

C. ADD NEW ELIGIBLE DEPENDENTS

NEWBORNS, ADOPTED CHILDREN, OR CHILDREN PLACED FOR ADOPTION MUST BE ADDED WITHIN 60 DAYS OF BIRTH OR ADOPTION (SEE REVERSE SIDE FOR MORE INFORMATION).

FIRST AND LAST NAME	SEX M/F	RELATIONSHIP	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY NUMBER	TOBACCO USER?
		❑ SPOUSE ❑ NATURAL CHILD ❑ ADOPTED			❑ YES ❑ NO
		❑ SPOUSE ❑ NATURAL CHILD ❑ ADOPTED			❑ YES ❑ NO

D. TERMINATE DEPENDENTS

CHILDREN (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION.)

FIRST AND LAST NAME	TERMINATION DATE MM/DD/YY	REASON
		❑ COVERAGE THROUGH OTHER PARENT (DIVORCE) ❑ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID) ❑ INDIVIDUAL COVERAGE ❑ OTHER _____
		❑ COVERAGE THROUGH OTHER PARENT (DIVORCE) ❑ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID) ❑ INDIVIDUAL COVERAGE ❑ OTHER _____

SPOUSE (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION.)

FIRST AND LAST NAME	TERMINATION DATE MM/DD/YY	REASON
		❑ ANNULMENT ❑ DEATH ❑ DIVORCE ❑ COVERAGE ON PARENT'S PLAN ❑ EMPLOYER GROUP COVERAGE ❑ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID) ❑ OTHER _____

By signing this form, I acknowledge that I will no longer have healthcare coverage through SelectHealth.

Spouse's Signature _____ **Date** _____

E. CANCEL COVERAGE

❑ I hereby request to stop receiving medical benefits received under Contract by SelectHealth®. I understand that this stoppage will be effective on the last day of the month following receipt and approval of this request by SelectHealth. Furthermore, I understand that no cancellation will be made on a retroactive basis.

If you would like a termination date other than the end of the month, write it in the space below. **We require 14 days notice to terminate your plan.**

Date _____

❑ I wish to stop receiving my medical benefits because I am leaving for active military service.

F. SIGNATURE

By signing, you agree to the changes requested above and acknowledge that your monthly premium may change. To terminate coverage, please mark a box in section "E." above before signing.

Subscriber Signature _____ **Date** _____

P.O. Box 30192
Salt Lake City, UT 84130-0192
800-538-5038/Fax 801-442-5798
selecthealth.org

selecthealth

Change Form Instructions

USE THE FOLLOWING GUIDELINES TO COMPLETE YOUR CHANGE REQUEST.

*For plans purchased through Your Health Idaho—Idaho's Health Insurance Exchange—all requested changes and terminations MUST be processed through the exchange. Visit **yourhealthidaho.org** or call **855-944-3246**.*

SECTION A. SUBSCRIBER INFORMATION

Complete this section using the policyholder's full name and ID number. You can find this number on your ID card. If you purchased your plan through the Health Insurance Exchange, certain changes must be made through the Exchange. For more information, contact your SelectHealth-appointed agent or call Individual Sales at **855-442-0220**.

SECTION B. SUBSCRIBER INFORMATION CHANGES

This section is only required for name, marital status, address, or phone number changes.

SECTION C. ADD ELIGIBLE DEPENDENT CHILDREN

Use this section only to add eligible dependents as outlined in your Contract. If you are adding a dependent outside of open enrollment, proof of a qualified life event will be required. Life events that may qualify you for a Special Enrollment Period (SEP) include getting married, having a baby, moving to a new residence, adopting a child, and more. For more information, call Individual Sales at **855-442-0220**.

SECTION D. TERMINATE DEPENDENTS

Use this section to remove your spouse or dependent children. Authorized removal of dependents may be done at any time during the year as long as SelectHealth is notified in advance. For more information, call Individual Sales at **855-442-0220**.

SECTION E. CANCEL COVERAGE

Complete this section if you wish to terminate your policy.

SECTION F. SIGNATURE

Only the subscriber's signature is acceptable. Unsigned change forms cannot be processed and will cause a delay in fulfilling your request.

Submit the completed change form to:
SelectHealth
P.O. Box 30192
Salt Lake City, UT 84130-0192
Fax: **801-442-5798**
Email: **individualenrollment@selecthealth.org**

When emailing sensitive information, please use your *My Health* account on **selecthealth.org**.