Fair Treatment Notice

Select Health 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.

We provide free:

- Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).
- Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call Select Health Member Services at **800-538-5038**.

If you feel you've been treated unfairly, call Select Health 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 Select Health.

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 Select Health

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्नुहोस्।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

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。Select Health. まで、お電話にてご連絡ください。

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። Select Health ን ያናግሩ።

ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте Select Health.

تنبيه: إذا كنت تتحدث عربى، فستتوفر لك خدمات المساعدة اللغوية مجانا. اتصل بـ Select Health.

توجه: اگر به زبان اردو صحبت می‌کنی، خدمات کمک زبانی، بصورت رایگان در اختیار شما ست. با Select Health تماس بگیری.

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Select Health: 1-800-538-5038

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

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# _____ Date of Birth _____
(LOCATED ON ID CARD)

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 _____

E. CANCEL COVERAGE

❑ (TO BE USED WHEN TERMINATING COVERAGE FOR SUBSCRIBER AND ALL DEPENDENTS)

I hereby request for myself and all of my dependents to stop receiving medical benefits received under Contract by Select Health®. I understand that this stoppage will be effective on the last day of the month following receipt and approval of this request by Select Health. 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 Select Health-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 Select Health 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:
Select Health
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**.