SelectHealth, Inc.
P.O. Box 30192
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selecthealth.

Idaho Change Form - (for members getting insurance through their employer)

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 ______________________

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[2] ❑ Obtained Other Coverage	❑ Marriage ❑ Divorce ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change __________ ❑ Divorce ❑ Court Order[1] ❑ Loss of Other Coverage[2] ❑ Obtained Other Coverage	❑ Marriage ❑ Newborn ❑ Adoption ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change __________ ❑ Divorce ❑ Court Order[1] ❑ Loss of Other Coverage[2] ❑ Obtained Other Coverage	❑ Marriage ❑ Newborn ❑ Adoption ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear ❑ HSA					Effective Date of Change __________ ❑ Divorce ❑ Court Order[1] ❑ Loss of Other Coverage[2] ❑ Obtained Other Coverage	❑ Marriage ❑ Newborn ❑ Adoption ❑ Death

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

1. If adding a dependent because of a court or administrative order, please attach a copy with this form.
2. If making a change because of loss of other coverage, complete the following: Carrier ____________ Coverage began/ended ____________

*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

(Employees applying for COBRA must complete a separate COBRA form)

Date of Termination ______________________

Term Reason: ❑ Voluntary ❑ Part Time ❑ Employment Termination

❑ Retirement ❑ Death ❑ Waiving due to coverage under spouse or parent

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 208-338-2001