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

selecthealth®

Change Form—UT (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 ______________ ❑ 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[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 you are adding a dependent because of a court or administrative order, please attach a copy with this form.
2. 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

GRP CHANGE 12/22