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

selecthealth®

Change Form Large Employer

Employee Name ______________________ Date of Birth ____________

Subscriber# ______________________ Social Security# ____________

A. EMPLOYEE INFORMATION CHANGE

New Mailing Address and Phone#

Street Address ______________ City ____________

State ________ ZIP ________ Ph#(_____) ____________

Name Change

From ____________

To ____________

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					Effective Date of Change Signature required (see section C) ❑ Loss of Other Coverage[3] ❑ Obtained Other Coverage ❑ Marriage ❑ Divorce[1] ❑ Death
Child	❑ Add ❑ Delete	❑ Medical ❑ Dental ❑ Eyewear					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					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					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, 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.
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, complete the information below:

Carrier ______________ Date Coverage Began ________ Date Coverage 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 **my** benefits. Check all that apply: ❑ **Medical** ❑ **Dental** ❑ **Eyewear**

Reason for Discontinuance ______________ Date of Discontinuance ________

I wish to discontinue my **spouse** or **ex-spouse's** benefits. Check all that apply: ❑ **Medical** ❑ **Dental** ❑ **Eyewear**

The spouse's or Ex-Spouse's signature is required below, unless the divorce decree is attached (see Note 1 above) for divorce situations.

Subscriber's Spouse or Ex-Spouse's Signature ______________ Date ________

D. EMPLOYEE SIGNATURE

Employee Signature ______________ **Date** ________

E. EMPLOYER USE

Employer Authorization ______________ Date ________

Company Name ______________ Group# ________

Comments ______________

Discontinuance of Medical Benefits

❑ Date of Termination ____________

Term Reason: ❑ Voluntary ❑ Part Time ❑ Employment Termination

❑ Date of Loss of Eligibility Status ____________

❑ Transfer Date From ________ To ________

❑ Date of Retirement ____________

❑ Date of Death ____________

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 ____________

Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at **1-800-538-5038**. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** 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**).

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Language Access Services

Spanish

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

Chinese

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**. 。

Vietnamese

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**.

Korean

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

번으로 전화해 주십시오.

Navajo

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

Nepali

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

Tongan

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**.

Serb-Croatian

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

Tagalog

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**.

German

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

Russian

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

Arabic

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

Mon-khmer, Cambodian

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

French

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

Japanese

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。