

## Change Form Large Employer

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Subscriber# \_\_\_\_\_ Social Security# \_\_\_\_\_

### A. EMPLOYEE INFORMATION CHANGE

**New Mailing Address and Phone#** \_\_\_\_\_ **Name Change** \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ From \_\_\_\_\_  
 State \_\_\_\_\_ ZIP \_\_\_\_\_ Ph#(\_\_\_\_\_) \_\_\_\_\_ 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	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Eyewear				Effective Date of Change _____ Signature required (see section C) <input type="checkbox"/> Loss of Other Coverage <sup>3</sup> <input type="checkbox"/> Obtained Other Coverage <span style="float: right;"> <input type="checkbox"/> Marriage  <input type="checkbox"/> Divorce<sup>1</sup>  <input type="checkbox"/> Death                     </span>
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Eyewear				Effective Date of Change _____ <input type="checkbox"/> Divorce <sup>1</sup> <input type="checkbox"/> Court Order <sup>2</sup> <input type="checkbox"/> Loss of Other Coverage <sup>3</sup> <input type="checkbox"/> Obtained Other Coverage <span style="float: right;"> <input type="checkbox"/> Marriage  <input type="checkbox"/> Newborn  <input type="checkbox"/> Adoption  <input type="checkbox"/> Death                     </span>
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Eyewear				Effective Date of Change _____ <input type="checkbox"/> Divorce <sup>1</sup> <input type="checkbox"/> Court Order <sup>2</sup> <input type="checkbox"/> Loss of Other Coverage <sup>3</sup> <input type="checkbox"/> Obtained Other Coverage <span style="float: right;"> <input type="checkbox"/> Marriage  <input type="checkbox"/> Newborn  <input type="checkbox"/> Adoption  <input type="checkbox"/> Death                     </span>
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Eyewear				Effective Date of Change _____ <input type="checkbox"/> Divorce <sup>1</sup> <input type="checkbox"/> Court Order <sup>2</sup> <input type="checkbox"/> Loss of Other Coverage <sup>3</sup> <input type="checkbox"/> Obtained Other Coverage <span style="float: right;"> <input type="checkbox"/> Marriage  <input type="checkbox"/> Newborn  <input type="checkbox"/> Adoption  <input type="checkbox"/> Death                     </span>

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

- 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.
- If you are adding a dependent because of a court or administrative order, please attach a copy with this form.
- 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 \_\_\_\_\_