P.O. Box 30192
Salt Lake City, UT 84130-0192
800-538-5038/Fax 801-442-0608
selecthealth.org

selecthealth

# Individual Plans Utah Change Form

**SEE REVERSE SIDE OF FORM FOR INSTRUCTIONS AND ADDITIONAL INFORMATION.**

## A. SUBSCRIBER INFORMATION

Subscriber's Name _____ Subscriber ID# _____ (LOCATED ON ID CARD) Date of Birth _____

## B. SUBSCRIBER INFORMATION CHANGES

Name Changed From _____ Marital Status Change ❑ Legally Married ❑ Divorced ❑ Death

Name Changed To _____ Effective Date of Marital Change _____

New Address _____ Unit/Apt.# _____

City _____ State _____ ZIP _____ New Ph# (_____)_____

## C. ADD ELIGIBLE DEPENDENT CHILDREN

**NEWBORNS, ADOPTED CHILDREN, OR CHILDREN PLACED FOR ADOPTION WITHIN 60 DAYS OF BIRTH OR ADOPTION (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)**

| FIRST AND LAST NAME | SEX M/F | RELATIONSHIP | DATE OF BIRTH MM/DD/YY |
|---|---|---|---|
| | | ❑ NATURAL ❑ ADOPTED | |
| | | ❑ NATURAL ❑ ADOPTED | |

## 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 ❑ INDIVIDUAL COVERAGE ❑ OTHER _____ |
| | | ❑ COVERAGE THROUGH OTHER PARENT (DIVORCE) ❑ GOVERNMENT COVERAGE ❑ INDIVIDUAL COVERAGE ❑ OTHER _____ |

**SPOUSE (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)**

| FIRST AND LAST NAME | TERMINATION DATE MM/DD/YY | REASON |
|---|---|---|
| | | ❑ ANNULMENT ❑ DEATH ❑ DIVORCE ❑ GOVERNMENT COVERAGE ❑ EMPLOYER GROUP COVERAGE ❑ COVERAGE ON PARENT'S PLAN |

By signing this form, I acknowledge that I will no longer have healthcare coverage through SelectHealth.

**Spouse's Signature** _____ **Date** _____

## E. BENEFIT CHANGES

**IF YOU WOULD LIKE TO MAKE BENEFIT CHANGES, PLEASE MARK THE BOX BELOW AND SUBMIT AN APPLICATION FORM. TO FIND AN APPLICATION, VISIT SELECTHEALTH.ORG. ALL CHANGES ARE SUBJECT TO SELECTHEALTH APPROVAL.**

❑ Application Form Attached

## F. DISCONTINUE MEDICAL BENEFITS

❑ I hereby request the discontinuance of medical benefits received under Contract by SelectHealth. I understand that the discontinuance will be effective on the last day of the month following receipt and approval of this request by SelectHealth. 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 discontinue my medical benefits because I am leaving for active military service.

## G. 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 "F" above before signing.

**Subscriber Signature** _____ **Date** _____

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# Change Form Instructions

## USE THE FOLLOWING GUIDELINES TO COMPLETE YOUR CHANGE REQUEST.

**SECTION A. SUBSCRIBER INFORMATION**
Complete this section using the policyholder's full name and Subscriber ID. You can find this number on your ID Card. If you purchased your plan through the Health Insurance Marketplace, certain changes may be made through the Marketplace. For more information, contact your SelectHealth-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. For more information for adding dependents outside of open enrollment, 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 SelectHealth is notified in advance. Unless you are terminating your entire policy, you may only terminate individual family members from the policy as outlined in your contract. For more information, call Individual Sales at 855-442-0220.

**SECTION E. BENEFIT CHANGES**
Changes can only be made during open enrollment or for a special enrollment. For more information about making benefit changes, refer to your Contract.

**SECTION F. DISCONTINUE MEDICAL BENEFITS**
Complete this section if you wish to terminate your policy.

**SECTION G. SIGNATURE**
Only the subscriber's signature is acceptable. Unsigned change forms cannot be processed and will cause a delay in fulfilling your request.