



Individual Plans Change Form

SEE REVERSE SIDE OF FORM FOR INSTRUCTIONS AND ADDITIONAL INFORMATION

A. SUBSCRIBER INFORMATION

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

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

USE THIS SECTION TO ADD ELIGIBLE CHILDREN. (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

FIRST AND LAST NAME	SEX M/F	RELATIONSHIP	DATE OF BIRTH MM/DD/YY
		<input type="checkbox"/> NATURAL <input type="checkbox"/> ADOPTED	
		<input type="checkbox"/> NATURAL <input type="checkbox"/> ADOPTED	

D. TERMINATE DEPENDENTS

USE THIS SECTION TO TERMINATE DEPENDENT CHILDREN. (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

FIRST AND LAST NAME	TERMINATION DATE MM/DD/YY	REASON
		<input type="checkbox"/> COVERAGE THROUGH OTHER PARENT (DIVORCE) <input type="checkbox"/> GOVERNMENT COVERAGE <input type="checkbox"/> INDIVIDUAL COVERAGE <input type="checkbox"/> OTHER _____
		<input type="checkbox"/> COVERAGE THROUGH OTHER PARENT (DIVORCE) <input type="checkbox"/> GOVERNMENT COVERAGE <input type="checkbox"/> INDIVIDUAL COVERAGE <input type="checkbox"/> OTHER _____

SPOUSE (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

FIRST AND LAST NAME	TERMINATION DATE	REASON
		<input type="checkbox"/> ANNULMENT <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> GOVERNMENT COVERAGE <input type="checkbox"/> EMPLOYER GROUP COVERAGE <input type="checkbox"/> COVERAGE ON PARENTS PLAN

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

Spouse's Signature _____ Date _____

E. BENEFIT CHANGES

BENEFIT CHANGES, OTHER THAN THOSE LISTED BELOW, REQUIRE THE SUBMISSION OF AN APPLICATION OR REAPPLICATION FORM. ALL CHANGES ARE SUBJECT TO UNDERWRITING APPROVAL. DEDUCTIBLE CANNOT BE LOWERED USING THIS CHANGE FORM.

INCREASE DEDUCTIBLE	CHANGE NETWORK	CHANGE PLAN	CHANGE TO A HEALTHSAVE (HSA-COMPATIBLE) PLAN
<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500	<input type="checkbox"/> Select Value SM <input type="checkbox"/> Select Med SM <input type="checkbox"/> Select Care SM	<input type="checkbox"/> Yes, change my policy to a Base Plan <input type="checkbox"/> Yes, change my policy to a Base Plan with office deductible waiver <input type="checkbox"/> Add Supplemental Accident coverage <input type="checkbox"/> Remove Supplemental Accident coverage	<input type="checkbox"/> \$1,300/\$2,600 <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$5,000/\$10,000 An HSA will be established for you with HealthEquity® (SelectHealth's preferred HSA vendor) if you choose this option. An administrative fee is included in your premium, regardless of whether you choose to use this vendor. <input type="checkbox"/> I choose to open an HSA with HealthEquity <input type="checkbox"/> I will use another HSA administrator or not open an HSA

Requested effective date of change _____

Any corresponding Rx deductibles and Rx out-of-pocket maximums will be adjusted according to the medical plan chosen. Refer to your Member Payment Summary (MPS) for these amounts.

F. RATE INCREASE REVIEW

I would like to request a review of my premium rate increase for reduction or removal.

G. DISCONTINUANCE OF 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.
- I wish to discontinue my medical benefits because I am leaving for active military service.

H. 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 "G." above before signing.

Subscriber Signature _____ Date _____

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 ID number. You can find this number on your ID card.

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 newborns, adopted children, or children placed for adoption. To add a spouse or dependent children age 19 or older, please complete a full Individual Plans Application Form instead of the Change Form.

Adding Newborn or Adopted Children

- Application must be made within 31 days from the child's date of birth, adoption, adoption placement, or placement under legal guardianship through testamentary appointment or court order.
- Submit a copy of placement or adoption papers with the Change Form.
- When adding a dependent older than 31 days of age, a full Individual Plans Application Form is required instead of the Change Form. Your dependent may only be added during the open enrollment period as outlined below.

Adding Dependents Ages 18 and Younger

- You may only add dependents ages 18 and younger during the open enrollment period before your policy renews. Dependent coverage will be effective on your renewal date.
 - > Policies renewing January 1 — enrollment period begins November 1
 - > Policies renewing July 1 — enrollment period begins May 1

SECTION D. TO 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 in the following circumstances:

Divorce or Annulment

- A spouse may be terminated in cases of divorce or annulment. Children age 18 or younger may also be terminated in certain divorce circumstances.
 - > If you have family coverage, you must submit the first and last pages of the divorce decree and any page specifying coverage responsibilities for dependent children.
 - > If you do not have family coverage, your spouse may sign the Change Form in Section "D" to acknowledge the request to discontinue coverage (or you may submit a copy of the first and last page of the divorce decree).

Other Circumstances

- Your spouse or children can be terminated in cases of death.
- You may terminate a child or spouse if he or she is covered by his or her employer or by a government plan (e.g., CHIP, HIPUtah, Federal-HIPUtah, Medicare, Medicaid).
- You may terminate your spouse if he or she is younger than age 26 and covered by his or her parents' plan.
- Dependent children ages 19 and older can be terminated at any time.

SECTION E. BENEFIT CHANGES

All options may not be available on your plan. Please contact your broker or SelectHealth to verify which options are available to you. If you are switching to a HealthSave plan, please be aware that changing back to a standard HMO plan will require medical underwriting.

SECTION F. RATE INCREASE REVIEW

- The policy must go through two renewal's before you are eligible for a rate increase reduction or removal.
- Your premium is not eligible for review if there was no increase to your current rate.

SECTION G. DISCONTINUANCE OF MEDICAL BENEFITS

Complete this section if you wish to terminate your policy.

SECTION H. SIGNATURE

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