Fair Treatment Notice

SelectHealth obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free:

> Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).

> Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call SelectHealth Member Services at 800-538-5038 or SelectHealth Advantage Member Services at 855-442-9900 (TTY users: 711).

If you feel you’ve been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at 1-844-208-9012 (TTY Users: 711) 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).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth.

Fair Treatment Notice
Individual Plans Nevada Change Form

SEE REVERSE SIDE OF FORM FOR INSTRUCTIONS

Note: If you purchased your plan through Nevada Health Link, all requested changes MUST be processed through their portal. Visit nevadahealthlink.com or call 800-547-2927.

A. SUBSCRIBER INFORMATION

Subscriber’s Name __________________________ Subscriber ID# __________________________ Date of Birth __________________________

(LOCATED ON ID CARD)

B. SUBSCRIBER INFORMATION CHANGES

Marital
Name Changed from __________________________ Status Change □ Legally Married □ Divorced □ Deceased
Name Changed to __________________________ Effective Date of Marital Status Change __________________________

New Physical Address __________________________

New Mailing Address __________________________

City __________________________ State __________________________ ZIP __________________________ New Ph# (______) __________________________

C. ADD NEW ELIGIBLE DEPENDENTS

NEWBORNS, ADOPTED CHILDREN, OR CHILDREN PLACED FOR ADOPTION MUST BE ADDED WITHIN 60 DAYS (WHEN THERE’S A CHANGE IN PREMIUM) OF GAINING THE DEPENDENT, OR 31 DAYS (WHEN THERE’S NO CHANGE TO PREMIUM) FROM WHEN THE FIRST CLAIM IS RECEIVED.

<table>
<thead>
<tr>
<th>FIRST AND LAST NAME</th>
<th>SEX M/F</th>
<th>RELATIONSHIP</th>
<th>DATE OF BIRTH MM/DD/YYYY</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>TOBACCO USER?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ SPouse □ Natural Child □ Adopted</td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ SPouse □ Natural Child □ Adopted</td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

D. TERMINATE DEPENDENTS

CHILDREN (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

<table>
<thead>
<tr>
<th>FIRST AND LAST NAME</th>
<th>TERMINATION DATE MM/DD/YYYY</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ COVERAGE THROUGH OTHER PARENT (DIVORCE) □ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID, ETC.) □ INDIVIDUAL COVERAGE □ OTHER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SPOUSE (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

<table>
<thead>
<tr>
<th>FIRST AND LAST NAME</th>
<th>TERMINATION DATE MM/DD/YYYY</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ ANNULMENT □ DEATH □ DIVORCE □ COVERAGE ON PARENT’S PLAN □ EMPLOYER GROUP COVERAGE □ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID) □ OTHER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Spouse’s Signature __________________________ Date __________________________

E. CANCEL COVERAGE

□ I hereby request to stop receiving medical benefits received under Contract by SelectHealth®. I understand that this stoppage 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.

Date __________________________

□ I wish to stop receiving my medical benefits because I am leaving for active military service.

F. 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 “E” above before signing.

Subscriber Signature __________________________ Date __________________________

I-NV CHANGE 01-01-22
USE THE FOLLOWING GUIDELINES TO COMPLETE YOUR CHANGE RE-

For plans purchased through the FFM, all requested changes and terminations MUST be processed through the FFM. Visit healthcare.gov or call 800-318-2596.

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 FFM, certain changes may be made through the FFM. 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. If you are adding a dependent outside of open enrollment, proof of a qualified life event will be required. Life events that may qualify you for a Special Enrollment Period (SEP) include getting married, having a baby, moving to a new residence, adopting a child, and more. For more information, 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. For more information, call Individual Sales at 855-442-0220.

SECTION E. CANCEL COVERAGE
Complete this section if you wish to terminate your policy.

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

Submit the completed change form to:
SelectHealth
P.O. Box 30192
Salt Lake City, UT 84130-0192
Fax: 801-442-5798
Email: individualenrollment@selecthealth.org

When emailing sensitive information, please use your My Health account on selecthealth.org.