P.O. Box 30192
Salt Lake City, UT 84130-0192
**844-345-FEHB**
**selecthealth.org/fehb**

selecthealth®

# FEHB Dependent Address Change Form

Use this form when your dependent* child moves out of the SelectHealth FEHB service area or to report that your dependent has moved back inside the service area. Beginning January 1, 2017, SelectHealth® offers participating benefits for covered services to enrolled dependent children who reside and receive services outside our service area. To qualify your out-of-area dependent for participating benefits, complete this form and send it to SelectHealth Enrollment by email (**shgovernmentenrollment@selecthealth.org**) or by fax (**801-442-0319**). For more information about the service area, refer to your plan materials or contact Member Services at **844-345-FEHB**.

Federal Employee/Annuitant Name ____________________ Date of Birth ____________

Subscriber# ____________________ Social Security# ____________________

Federal Employee/Annuitant Phone# ____________________

*Federal employees, annuitants, and spousal dependents are not eligible for this extended out-of-area coverage.

## A. DEPENDENT INFORMATION CHANGE

**Dependent's New Address and Phone**

Name (first, middle, last) ____________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ____________ Date of Address Change (MM/DD/YY) ____________

New Street Address ____________________ City ____________

Social Security#* ____________ State ______ ZIP ________ Ph#(____) ____________

**Dependent's New Address and Phone**

Name (first, middle, last) ____________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ____________ Date of Address Change (MM/DD/YY) ____________

New Street Address ____________________ City ____________

Social Security#* ____________ State ______ ZIP ________ Ph#(____) ____________

**Dependent's New Address and Phone**

Name (first, middle, last) ____________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ____________ Date of Address Change (MM/DD/YY) ____________

New Street Address ____________________ City ____________

Social Security#* ____________ State ______ ZIP ________ Ph#(____) ____________

*Federal law section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 requires SelectHealth to gather this information.

## B. FEDERAL EMPLOYEE/ANNUITANT SIGNATURE

I wish to change my dependent's address as indicated above. To receive participating benefits, my dependent will need to receive care from providers on one of the following networks when outside of the plan's service area: Select Med® (UT), St. Luke's Health Partners, BrightPath (ID), Beech Street (AK & NV), First Choice (MT & WA), or PHCS/MultiPlan (other states).

**Federal Employee/Annuitant Signature** ____________________ **Date** ____________

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