

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 <input type="checkbox"/> HSA					Effective Date of Change _____ Signature required (see section C) <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Obtained Other Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce¹ <input type="checkbox"/> Death
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Eyewear <input type="checkbox"/> HSA					Effective Date of Change _____ <input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Court Order ² <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Obtained Other Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Eyewear <input type="checkbox"/> HSA					Effective Date of Change _____ <input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Court Order ² <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Obtained Other Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Eyewear <input type="checkbox"/> HSA					Effective Date of Change _____ <input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Court Order ² <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Obtained Other Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death

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

1. 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.
2. If you are adding a dependent because of a court or administrative order, please attach a copy with this form.
3. 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** **HSA**
 Reason for Discontinuance _____ Date of Discontinuance _____

I wish to discontinue my **spouse** or **ex-spouse's** benefits. Check all that apply: **Medical** **Dental** **Eyewear** **HSA**
 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 _____