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

selecthealth

Change Form Idaho Small Employer

Complete Applicable Sections Only

Employee Name _____ Subscriber ID# _____ Date of Birth _____

A. EMPLOYEE/DEPENDENT INFORMATION CHANGE

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

Name Changed To _____ Date of Marital Change _____

New Address _____

City _____ State _____ ZIP _____ New Ph# _____

B. ADD NEWBORN/ADOPTED CHILD ONLY

Use this section only to add newborn children, adopted children, or children placed for adoption. All other dependents must submit a completed Employee Application.

Last Name	First Name	Initial	Coverage		Sex	Relationship	Date of Birth (MM/DD/YY)
			Medical	Eyewear			
1.					M/F	❑ Natural ❑ Adopted*	
2.					M/F	❑ Natural ❑ Adopted*	

*Submit copy of adoption or placement papers

C. DELETE FAMILY MEMBERS

Delete Children

Last Name	First Name	Initial	Coverage		Effective Date (MM/DD/YY)	Reason
			Medical	Eyewear		
1.						
2.						
3.						

Delete Spouse

Last Name	First Name	Initial	Coverage		Effective Date (MM/DD/YY)
			Medical	Eyewear	

Reason

❑ Death ❑ Annulment
❑ Divorce ❑ Other
❑ Open Enrollment

If you are deleting coverage for your spouse as a result of a divorce or annulment, please complete the following:

❑ **If you have family coverage,** you must submit the first and last page of the divorce decree and any page specifying coverage responsibilities for dependent children.

❑ **If you do not have family coverage,** your spouse may sign this form below acknowledging the request to discontinue coverage, or you may submit a copy of the first and last page of the divorce decree.

By signing this form, I acknowledge that I will no longer have healthcare coverage through SelectHealth. I understand that I may have rights to continue coverage as the result of my recent divorce and that additional information regarding how to continue coverage may be obtained through the Plan sponsor (spouse's employer).

Spouse's Signature _____ **Date** _____

Except for when spouse is deceased or at open enrollment, spouse's signature is required.

D. EMPLOYEE TERMINATION OF MEDICAL AND/OR EYEWEAR BENEFITS (Check any applicable boxes for employee only)

Actual Date of Change _____ (Last day worked/lost eligibility/retired, etc.)

❑ Termination of employment
❑ Retirement
❑ Death (employee signature not required)
❑ Leaving for active military service

Both employer and employee must sign this form.

❑ Loss of eligibility (i.e. full to part-time but still employed)
❑ Termination of COBRA coverage
❑ Waiving coverage (due to coverage under a spouse or parent plan)

❑ No longer want coverage (subject to group participation requirements)
❑ Medical ❑ Eyewear

E. EMPLOYEE SIGNATURE

By signing, you agree to the changes requested above.

Employee's Signature _____ **Date** _____

F. EMPLOYER INFORMATION (Must be completed)

Note: If an employee is applying for COBRA coverage, proof of COBRA eligibility may be required. Employees applying for COBRA coverage must complete a separate COBRA Form. COBRA questions can be answered by calling 866-444-3272. COBRA Forms can be obtained by calling 801-442-5615.

After completing this Change Form, return by faxing to 208-338-2001.

Employer's Signature _____ Date _____

Company Name _____ Group# _____

Comments _____