P.O. Box 30192
Salt Lake City, UT 84130-0192
800-538-5038/Fax 801-442-5798
selecthealth.org

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Individual Plans Utah Change Form

SEE REVERSE SIDE OF FORM FOR INSTRUCTIONS AND ADDITIONAL INFORMATION.

Please Note: *For plans purchased through the Health Insurance Marketplace, all requested changes and terminations MUST be processed through the exchange. Visit* ***healthcare.gov*** *or call* ***800-318-2596****.*

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 ❑ Deceased

Name Changed To _____ Effective Date of Marital Status Change _____

New Address _____ Unit/Apt.# _____

City _____ State _____ ZIP _____ New Ph# (_____)_____

C. ADD ELIGIBLE DEPENDENTS

NEWBORNS, ADOPTED CHILDREN, OR CHILDREN PLACED FOR ADOPTION MUST BE ADDED/REMOVED WITHIN 60 DAYS OF BIRTH OR ADOPTION (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION).

FIRST AND LAST NAME	SEX M/F	RELATIONSHIP	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY NUMBER	DO YOU USE TOBACCO?
		❑ SPOUSE ❑ NATURAL CHILD ❑ ADOPTED			❑ YES ❑ NO
		❑ SPOUSE ❑ NATURAL CHILD ❑ ADOPTED			❑ YES ❑ NO

D. TERMINATE DEPENDENTS

CHILDREN (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

FIRST AND LAST NAME	TERMINATION DATE MM/DD/YY	REASON
		❑ COVERAGE THROUGH OTHER PARENT (DIVORCE) ❑ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID ETC.) ❑ INDIVIDUAL COVERAGE ❑ OTHER _____
		❑ COVERAGE THROUGH OTHER PARENT (DIVORCE) ❑ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID ETC.) ❑ INDIVIDUAL COVERAGE ❑ OTHER _____

SPOUSE (SEE REVERSE SIDE FOR ADDITIONAL INFORMATION)

FIRST AND LAST NAME	TERMINATION DATE MM/DD/YY	REASON
		❑ ANNULMENT ❑ DEATH ❑ DIVORCE ❑ COVERAGE ON PARENT'S PLAN ❑ EMPLOYER GROUP COVERAGE ❑ GOVERNMENT COVERAGE (E.G., MEDICARE, MEDICAID ETC.) ❑ OTHER _____

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

Spouse's Signature _____ **Date** _____

E. DISCONTINUE 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.

If you would like a termination date other than the end of the month, write it in the space below. We require 14 days notice to terminate your plan.

Date _____

❑ I wish to discontinue 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** _____

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Change Form Instructions

USE THE FOLLOWING GUIDELINES TO COMPLETE YOUR CHANGE REQUEST.

Please Note: *For plans purchased through the Health Insurance Marketplace, all requested changes and terminations MUST be processed through the exchange. 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 Health Insurance Marketplace, certain changes may be made through the Marketplace. 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. 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. DISCONTINUE MEDICAL BENEFITS
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: **enrollment@selecthealth.org**

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

Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at **1-800-538-5038**. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** 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**).

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Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **1-800-538-5038**.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **1-800-538-5038**. 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **1-800-538-5038**.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **1-800-538-5038**.

번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę'', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih SelectHealth: **1-800-538-5038**.

Nepali

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नम्ित भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

Tongan

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

Arabic

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بشركة SelectHealth: **1-800-538-5038**.

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សូរៀបំនួយផ្នែកភាសា ដាយមិនគិតថ្លៃ គឺអាចមានសរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **1-800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**. まで、お電話にてご連絡ください。