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

selecthealth®

Dependent Address Change Form (for members who get insurance through their employer)

Use this form when your dependent child moves out of your service area or to report if your dependent child has moved back inside the service area. SelectHealth® offers participating benefits for covered services to enrolled dependent children who reside and receive services outside their service area. To qualify your out-of-area dependent child for participating benefits, complete this form and send it to SelectHealth Enrollment by email (**enrollment@selecthealth.org**) or by fax (**801-442-5798**). For more information about your service area, refer to your plan materials or contact Member Services.

Employee Name ______________________ Date of Birth ______________

Subscriber# ______________________ Social Security# ______________

A. DEPENDENT INFORMATION CHANGE

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ______

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ______

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ______

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ______

Date of Birth (MM/DD/YY) ______________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ______________ Date of Address Change ______________

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

C. EMPLOYEE SIGNATURE

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

** Dependent children of SelectHealth Share℠ members will also have participating benefits when receiving services from Select Care® providers when they move outside the SelectHealth Share service area and use this form.

Employee Signature ______________________ **Date** ______________

D. EMPLOYER USE

Employer Authorization ______________________ Date ______________

Company Name ______________________ Group# ______________

Comments ____

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。