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

FEHB Dependent Address Change Form

(for members enrolled in the FEHB High Deductible Health Plan (HDHP) option)

If you are enrolled in the Select Health FEHB HDHP Option, use this form when your dependent* moves outside of the Select Health FEHB service area (Utah) or to report that your dependent has moved back into the service area. Select Health® 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 Select Health Enrollment by email (**FEHBEnroll@imail.org**) or by fax (**801-442-9873**). 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 (MM/DD/YY) ____________

Subscriber ID # (found on your Select Health ID card) ____________________ Social Security #** ____________ *(Required)*

Phone #(______) ____________ Street Address ____________________

City ____________________ State ____________ ZIP ____________

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

A. DEPENDENT INFORMATION CHANGE

Dependent's New Address

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 #** ____________ *(Required)* State ______ ZIP ______ Phone #(______) ____________

Dependent's New Address

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 #** ____________ *(Required)* State ______ ZIP ______ Phone #(______) ____________

Dependent's New Address

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 #** ____________ *(Required)* State ______ ZIP ______ Phone #(______) ____________

**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 the appropriate local networks (as indicated on my SelectHealth ID card) when outside of the plan's service area.

Federal Employee/Annuitant Signature ____________________ **Date (MM/DD/YY)** ____________

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting Select Health: **844-345-3342**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

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