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

Change Form - UT (Individual Plans)

SEE REVERSE SIDE OF FORM FOR

Note: *For plans purchased through the Federally Facilitated Marketplace (FFM), all requested changes and terminations MUST be processed through the FFM. 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 Physical Address _____

New Mailing Address _____

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

C. ADD NEW ELIGIBLE DEPENDENTS

NEWBORNS, ADOPTED CHILDREN, OR CHILDREN PLACED FOR ADOPTION MUST BE ADDED WITHIN 60 DAYS (WHEN THERE'S A CHANGE IN PREMIUM) OF GAINING THE DEPENDENT, OR 31 DAYS (WHEN THERE'S NO CHANGE TO PREMIUM) FROM WHEN THE FIRST CLAIM IS RECEIVED.

FIRST AND LAST NAME	SEX M/F	RELATIONSHIP	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY NUMBER	TOBACCO USER?
		❑ 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) ❑ OTHER _____

E. CANCEL COVERAGE

❑ I hereby request to stop receiving medical benefits received under Contract by Select Health®. I understand that this stoppage will be effective on the last day of the month following receipt and approval of this request by Select Health. 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.

Date _____

❑ I wish to stop receiving 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** _____

Change Form Instructions

USE THE FOLLOWING GUIDELINES TO COMPLETE YOUR CHANGE REQUEST.

*For plans purchased through the FFM, all requested changes and terminations MUST be processed through the FFM. 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 FFM, certain changes may be made through the FFM. For more information, contact your Select Health-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. Life events that may qualify you for a Special Enrollment Period (SEP) include getting married, having a baby, moving to a new residence, adopting a child, and more. 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 Select Health is notified in advance. For more information, call Individual Sales at **855-442-0220**.

SECTION E. CANCEL COVERAGE
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:
Select Health
P.O. Box 30192
Salt Lake City, UT 84130-0192
Fax: **801-442-5798**
Email: **individualenrollment@selecthealth.org**

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