Complete Applicable Sections Only

4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 1-801-442-5038/1-800-538-5038 www.selecthealth.org

Small Employer Products

Change Form

Employee Name ________________ Subscriber# ________________ Date of Birth________________

Employee Information Change

Name Changed From ________________ Marital Status Change ❑ Marriage ❑ Divorced ❑ Death

Name Changed To ________________ Effective Date of Marital Change ________________

New Address________________ Unit/Apt# ________________

City ________________ State ________ ZIP ________________ New Ph#________________

Add Newborn/Adopted Child Only

Use this section only to add newborn children, adopted children, or children placed for adoption. This Change Form must be submitted within **31 days** from the child's date of birth, adoption, or placement for adoption. All other dependents must submit a completed SE Employee Application.

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

*Submit copy of adoption or placement papers

Delete Family Members

Delete Children

Last Name	First Name	Initial	Relationship	Effective Date (MM/DD/YY)	Reason
1.			Child		
2.			Child		
3.			Child		

Delete Spouse

Last Name	First Name	Initial	Relationship	Effective Date (MM/DD/YY)	Reason
1.			Spouse		❑ Death ❑ Annulment* ❑ Divorce* ❑ Other ❑ Open Enrollment

*If you are deleting coverage for your spouse as a result of a recent divorce or annulment, please follow the steps below:

❑ **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[SM]/SelectHealthBenefit Assurance Company[SM]. 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 the reason of death or at open enrollment, spouse's signature is required.

Employee Termination/Discontinue Medical Benefits (complete for employee only)

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

Check One

❑ Termination of employment (employee signature not required)
❑ Retirement
❑ Death
❑ Leaving for active military service
❑ Termination of Utah mini-COBRA or COBRA coverage
❑ Applying for Utah mini-COBRA**
❑ Loss of eligibility (full to part-time, etc. but still employed)
❑ Waiving coverage (due to group coverage under a spouse or parent plan only). Must submit a Waiver Form.
❑ No longer want coverage

(Six months of continuous group coverage through your current employer is required for Utah mini-COBRA. **Both employer and employee must sign this Change Form.)

Employee Signature

By signing, you agree to the changes requested above.

Employee's Signature ________________ Date ________________

Employer Section (must be completed for all changes)

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 Application Form. COBRA questions can be answered by calling 1-415-975-4600. COBRA forms can be obtained by calling 1-801-442-5615. After completing this Change Form, return by faxing to 1-801-442-5798.

Employer's Signature ________________ Date ________________

Group Name ________________ Group#________________

Comments________________

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