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selecthealth®

Change Form Large Employer

Employee Name ______________________ Date of Birth ______________

Subscriber# ______________________ Social Security# ______________

A. EMPLOYEE INFORMATION CHANGE

New Mailing Address and Phone#

Street Address ______________ City ______________

State ________ ZIP ________ Ph#(_____) ______________

Name Change

From ______________

To ______________

B. ADDITION OR DELETION OF FAMILY MEMBERS

	CHANGE	PLAN	NAME (LAST, FIRST, MIDDLE INITIAL)	SEX M/F	DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER*	REASON
Spouse	☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Eyewear					Effective Date of Change Signature required (see section C) ☐ Loss of Other Coverage[3] ☐ Obtained Other Coverage ☐ Marriage ☐ Divorce[1] ☐ Death
Child	☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Eyewear					Effective Date of Change ☐ Divorce[1] ☐ Court Order[2] ☐ Loss of Other Coverage[3] ☐ Obtained Other Coverage ☐ Marriage ☐ Newborn ☐ Adoption ☐ Death
Child	☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Eyewear					Effective Date of Change ☐ Divorce[1] ☐ Court Order[2] ☐ Loss of Other Coverage[3] ☐ Obtained Other Coverage ☐ Marriage ☐ Newborn ☐ Adoption ☐ Death
Child	☐ Add ☐ Delete	☐ Medical ☐ Dental ☐ Eyewear					Effective Date of Change ☐ Divorce[1] ☐ Court Order[2] ☐ Loss of Other Coverage[3] ☐ Obtained Other Coverage ☐ Marriage ☐ Newborn ☐ Adoption ☐ Death

NOTES: You must give proof of prior coverage to SelectHealth within 60 days.

1. If you are making a change because of a divorce, you must attach a copy of the divorce decree with this Change Form. You should include the first page of the decree, the signature page, and any other portion(s) that specifies responsibility for dependent coverage.
2. If you are adding a dependent because of a court or administrative order, please attach a copy with this form.
3. If you are making a change because of a loss of other coverage, complete the information below:

Carrier ______________ Date Coverage Began ________ Date Coverage Ended ________

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

C. DISCONTINUANCE OF BENEFITS

I wish to discontinue **my** benefits. Check all that apply: ☐ **Medical** ☐ **Dental** ☐ **Eyewear**

Reason for Discontinuance ______________ Date of Discontinuance ________

I wish to discontinue my **spouse** or **ex-spouse's** benefits. Check all that apply: ☐ **Medical** ☐ **Dental** ☐ **Eyewear**

The spouse's or Ex-Spouse's signature is required below, unless the divorce decree is attached (see Note 1 above) for divorce situations.

Subscriber's Spouse or Ex-Spouse's Signature ______________ Date ________

D. EMPLOYEE SIGNATURE

Employee Signature ______________ **Date** ________

E. EMPLOYER USE

Employer Authorization ______________ Date ________

Company Name ______________ Group# ________

Comments ______________

Discontinuance of Medical Benefits

☐ Date of Termination ______________

Term Reason: ☐ Voluntary ☐ Part Time ☐ Employment Termination

☐ Date of Loss of Eligibility Status ______________

☐ Transfer Date From ________ To ________

☐ Date of Retirement ______________

☐ Date of Death ______________

Leave of Absence

☐ Leaving for Active Military Service ______________

Coverage to Remain Active ☐ Yes ☐ No

☐ Taking a Leave of Absence Date ________ Expected Return Date ________

Coverage to Remain Active ☐ Yes ☐ No

☐ Return from a Leave of Absence/Military Service

Date ______________