



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.        |            |         |     | <input type="checkbox"/> Natural <input type="checkbox"/> Adopted* |                          |
| 2.        |            |         |     | <input type="checkbox"/> Natural <input type="checkbox"/> 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       |                           | <input type="checkbox"/> Death <input type="checkbox"/> Annulment*<br><input type="checkbox"/> Divorce* <input type="checkbox"/> Other<br><input type="checkbox"/> 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<sup>SM</sup>/SelectHealthBenefit Assurance Company<sup>SM</sup>. 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).

**Except for the reason of death or at open enrollment, spouse's signature is required.**

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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

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

\*\* (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 \_\_\_\_\_