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selecthealth℠

Individual Plans Change Form

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 ❑ Death

Name Changed To ____________________ Effective Date of Marital Change ____________________

New Address ____________________ Unit/Apt.# ____________________

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

C. ADD ELIGIBLE DEPENDENTS

USE THIS SECTION ONLY TO ADD AN ELIGIBLE NEWBORN, ADOPTED CHILDREN*, OR CHILDREN PLACED FOR ADOPTION*. APPLICATION MUST BE MADE WITHIN 31 DAYS FROM THE CHILD'S DATE OF BIRTH, ADOPTION, OR ADOPTION PLACEMENT.

LAST NAME	FIRST NAME	INITIAL	SEX M/F	RELATIONSHIP	DATE OF BIRTH MM/DD/YY
				❑ NATURAL ❑ ADOPTED	
				❑ NATURAL ❑ ADOPTED	

*SUBMIT A COPY OF PLACEMENT OR ADOPTION PAPERS

D. DELETE ELIGIBLE DEPENDENTS

DELETION OF CHILDREN

LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	TERMINATION DATE MM/DD/YY	REASON
			CHILD		
			CHILD		

DELETION OF SPOUSE

LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	TERMINATION DATE	REASON
			SPOUSE		❑ DEATH ❑ ANNUL* ❑ DIVORCE* ❑ OTHER

***DIVORCE OR ANNULMENT** If you are dropping coverage for your spouse as a result of a recent divorce or annulment, please follow the steps outlined below.

- ❑ If you have family coverage, you must submit the first and last pages 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.

Spouse's Signature ____________________ **Date** ____________________

E. BENEFIT CHANGES

BENEFIT CHANGES, OTHER THAN THOSE LISTED BELOW, REQUIRE THE SUBMISSION OF AN APPLICATION OR REAPPLY FORM. ALL CHANGES ARE SUBJECT TO UNDERWRITING APPROVAL. DEDUCTIBLE CANNOT BE LOWERED USING THIS CHANGE FORM.

INCREASE DEDUCTIBLE LEVEL*	CHANGE PLAN*	CHANGE TO A HEALTHSAVE (HSA-COMPATIBLE) PLAN
❑ $500 ❑ $1,000 ❑ $2,000 ❑ $2,500 ❑ $3,000 ❑ $5,000 ❑ $7,500	❑ Yes, change my policy to a "Base-Level" plan ❑ Yes, change my policy to a "Mid-Level" plan ❑ Add Supplemental Accident coverage ❑ Remove Supplemental Accident coverage	❑ $1,200/$2,400 ❑ $1,500/$3,000 ❑ $2,500/$5,000 ❑ $5,000/$10,000 An HSA will be established for you with HealthEquity® (SelectHealth's preferred HSA vendor), if you choose this option. An administrative fee is included in your premium, regardless of whether you choose to use this vendor. **❑ I choose to open an HSA account with HealthEquity** **❑ I will use another HSA administrator or not open an HSA**

Requested effective date of change ____________________

*Not all options may be available on your plan. Please contact your agent to verify which options are available to you. If changing to a HealthSave plan, please be aware that changing back to a standard HMO plan will require proof of insurability.
Any corresponding Rx deductibles and Rx out-of-pocket maximums will be adjusted accordingly. Refer to your contract for these amounts.

F. DISCONTINUANCE OF MEDICAL BENEFITS

- ❑ I hereby request the discontinuance of medical benefits received under Contract by SelectHealth. I understand that the discontinuance will be effective on the last day of the month following receipt and approval of this request by SelectHealth. Furthermore, I understand that no cancellation will be made on a retroactive basis.
- ❑ I wish to discontinue my medical benefits because I am leaving for active military service.

G. SIGNATURE

By signing, you agree to the changes requested above. To terminate coverage, please mark a box in section "F." above before signing.

Subscriber Signature ____________________ **Date** ____________________

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