



KidsSM Plan 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
 Name Changed To _____ Effective Date of Marital Change _____
 New Address _____ Unit# _____
 City _____ State _____ ZIP _____ New Phone#(_____) _____

C. BENEFIT CHANGES

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

INCREASE DEDUCTIBLE LEVEL	CHANGE PLAN
<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	<input type="checkbox"/> Yes, change my policy to a "Base-Level" plan

Requested effective date of change _____

D. 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.

E. TRANSFER COVERAGE TO AN INDIVIDUAL PLAN AND ADD A DEPENDENT

SelectHealth Kids plan subscribers can transfer coverage to a traditional SelectHealth individual plan if they need to add an eligible dependent (e.g., a spouse, newborn or adopted child, or other eligible dependent). The Kids plan subscriber will be moved without further medical underwriting to the current individual plan with the most comparable deductible and benefits that was offered at the time the subscriber enrolled on the Kids plan. In the event the dependent is not approved for coverage, the subscriber will be allowed to remain on the Kids plan according to the eligibility guidelines outlined in the contract. The effective date of this change will be the effective date of the added dependent(s).

ADD A NEWBORN

- I wish to transfer my coverage to an individual plan and add my newborn child to my plan. I understand the newborn child will be automatically added to the plan without being medically underwritten if this form is submitted within 31 days of the date of his or her birth. I also understand the newborn **will be** medically underwritten if this form is submitted more than 31 days after the date of his or her birth.

Complete the following information if adding a newborn within 31 days of the date of birth. To add a newborn after 31 days of the date of birth, complete a separate Individual Plans Application Form (available from your SelectHealth-appointed insurance agent or at www.selecthealth.org).

LAST NAME	FIRST NAME	INITIAL	SEX (M/F)	RELATIONSHIP	DATE OF BIRTH (MM/DD/YY)
				<input type="checkbox"/> NATURAL <input type="checkbox"/> ADOPTED	

ADD OTHER DEPENDENT (SPOUSE OR CHILD)

- I wish to transfer my coverage to an individual plan and add a dependent to my plan. I understand my dependent will need to submit a separate Individual Plans Application Form (available from my SelectHealth-appointed insurance agent or at www.selecthealth.org) to be added to the plan and will be medically underwritten. I will submit the application for the dependent with this change form.

F. SIGNATURE OF CHILD OR PARENT/GUARDIAN

By signing, you agree to the changes requested above. To terminate coverage, please mark a box in Section D. "Discontinuance of Medical Benefits" before signing.

Signature _____ Date _____

SELECTHEALTH USE ONLY

Plan ID# _____ Rate _____ Effective Date _____

Sales Approval _____ End Date _____