

Change Form

Employee Name _____ Member ID# _____

EMPLOYEE INFORMATION CHANGE

New Mailing Address & Phone#
Name Change

Street _____ City _____ From _____

State _____ ZIP _____ Phone# _____ To _____

Marital Status Change Single Married Separated Divorced **Effective Date** _____

ADDITION OR DELETION OF FAMILY MEMBERS

	CHANGE	NAME (LAST, FIRST, MIDDLE INITIAL)	SEX M/F	BIRTH DATE (MM/DD/YY)	REASON
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Court Order ² <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Reached Limiting Age <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Court Order ² <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Reached Limiting Age <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Court Order ² <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Reached Limiting Age <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death
Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete				<input type="checkbox"/> Divorce ¹ <input type="checkbox"/> Court Order ² <input type="checkbox"/> Loss of Other Coverage ³ <input type="checkbox"/> Reached Limiting Age <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Death

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

- 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.
- If you are adding a dependent because of a court or administrative order, please attach a copy with this form.
- If you are making a change because of a loss of other coverage, complete the information below:

Carrier _____ Date Coverage Began _____ Date Coverage Ended _____

Carrier _____ Date Coverage Began _____ Date Coverage Ended _____

DISCONTINUANCE OF MEDICAL BENEFITS

- I wish to discontinue my medical benefits.
- I wish to discontinue my spouse's medical benefits. A copy of the divorce decree (see Note 1 above) must be attached, or the spouse's signature is required below.

Reason for Discontinuance _____ Date of Discontinuance _____

Subscriber's Signature _____ Date _____

Subscriber's Spouse's Signature _____ Date _____

(Only required if a copy of the divorce decree is not provided.)

EMPLOYEE SIGNATURE

Employee Signature _____ Date _____

EMPLOYER USE

Employer Authorization _____ Date _____

Company Name _____ Group# _____

Comments _____

Discontinuance of Medical Benefits
 Date of Termination _____

 Date of Loss of Eligibility Status _____

 Transfer Date _____ From _____ To _____

 Date of Retirement _____

 Date of Death _____

 Leaving for Active Military Service _____

Leave of Absence
 Taking a Leave of Absence Date _____ Expected Return Date _____

 Return from a Leave of Absence _____ Date _____

Describe the Coverage Option Selected (as described in the Master Group Contract)