SelectHealth, Inc.
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selecthealth.

Dependent Address Change Form

(for members who get insurance through their employer)

Use this form when your Dependent moves out of your Service Area and to report when your Dependent has moved back inside the Service Area. Please complete the form and submit to your Human Resources department for signature. Please send the completed form to SelectHealth Enrollment by email (**SHLEENR@selecthealth.org**) or by fax (**385-297-2064**). For more information about your Service Area, refer to your plan materials or contact Member Services at 800-538-5038.

Employee Name ______________________ Date of Birth ______________

Subscriber# ______________________ Social Security# ______________

A. DEPENDENT INFORMATION CHANGE

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ____________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ____________ Date of Address Change ____________

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ____________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ____________ Date of Address Change ____________

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ____________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ____________ Date of Address Change ____________

Dependent's New Address and Phone

Name (first, middle, last) ______________________ Sex (M/F) ________

Date of Birth (MM/DD/YY) ____________ Social Security#* ______________

New Street Address ______________________ City ______________

State ________ ZIP ________ Ph#(______) ____________ Date of Address Change ____________

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

C. EMPLOYEE SIGNATURE

I wish to change my Dependent's address as indicated above. To receive in-network benefits, my dependent child will need to receive care from providers on one of the following networks when outside of my plan's service area: SelectHealth Med (UT)**. SelectHealth (ID). SelectHealth Value (NV), or other networks as listed on SelectHealth.org.

** Dependents of SelectHealth Share members will also receive in-network benefits when receiving services from SelectHealth Med providers when they move outside the SelectHealth Share service area and use this form.

Employee Signature ______________________ Date ______________

D. EMPLOYER USE

Employer Authorization ______________________ Date ______________

Company Name ______________________ Group # ______________

Comments ____