

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 _____