P.O. Box 30192
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selecthealth®

Dependent Address Change Form (for members who get insurance through their employer)

Use this form when your dependent child moves out of your service area or to report if your dependent has moved back inside the service area. SelectHealth® offers participating benefits for covered services to enrolled dependent children who reside and receive services outside their service area. To qualify your out-of-area dependent for participating benefits, complete this form and send it to SelectHealth Enrollment by email (**enrollment@selecthealth.org**) or by fax (**801-442-5798**). For more information about your service area, refer to your plan materials or contact Member Services.

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#(________) ______________

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#(________) ______________

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#(________) ______________

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#(________) ______________

*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 participating benefits, my dependent will need to receive care from providers on one of the following networks when outside of my plan's service area: Select Med® (UT)**, BrightPath (ID), Beech Street (AK & NV), First Choice (MT & WA), or PHCS/MultiPlan (other states).

** Dependent children of SelectHealth Share℠ members will also have participating benefits when receiving services from Select Care® 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 ____