

## Change Form Small Employer

### Complete Applicable Sections Only

Employee Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_ Date of Birth \_\_\_\_\_

#### A. EMPLOYEE INFORMATION CHANGE

 Name Changed From \_\_\_\_\_ Marital Status Change  Legally Married  Divorced  Death

Name Changed To \_\_\_\_\_ Effective Date of Marital Change \_\_\_\_\_

New Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ New Ph# \_\_\_\_\_

#### B. ADD NEWBORN/ADOPTED CHILD ONLY

 Use this section only to add newborn children, adopted children, or children placed for adoption. This Change Form must be submitted within **31 days** from the child's date of birth, adoption, or placement for adoption. All other dependents must submit a completed Employee Application.

	Last Name	First Name	Initial	Coverage		Sex	Relationship	Date of Birth (MM/DD/YY)
				Medical	Dental			
1.						M/F	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted*	
2.						M/F	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted*	

\*Submit copy of adoption or placement papers

#### C. DELETE FAMILY MEMBERS

##### Delete Children

	Last Name	First Name	Initial	Coverage		Effective Date (MM/DD/YY)	Reason
				Medical	Dental		
1.							
2.							
3.							

##### Delete Spouse

	Last Name	First Name	Initial	Coverage		Effective Date (MM/DD/YY)	Reason
				Medical	Dental		
							<input type="checkbox"/> Death <input type="checkbox"/> Annulment* <input type="checkbox"/> Divorce* <input type="checkbox"/> Other <input type="checkbox"/> Open Enrollment

\*If you are deleting coverage for your spouse as a result of a recent divorce or annulment, please complete the following:

- If you have family coverage**, you must submit the first and last page of the divorce decree and any page specifying coverage responsibilities for dependent children.
- If you do not have family coverage**, your spouse may sign this form below acknowledging the request to discontinue coverage, or you may submit a copy of the first and last page of the divorce decree.

By signing this form, I acknowledge that I will no longer have healthcare coverage through SelectHealth/SelectHealth Benefit Assurance Company. I understand that I may have rights to continue coverage as the result of my recent divorce and that additional information regarding how to continue coverage may be obtained through the Plan sponsor (spouse's employer).

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Except for the reason of death or at open enrollment, spouse's signature is required.

#### D. EMPLOYEE TERMINATION/DISCONTINUATION OF MEDICAL AND/OR DENTAL BENEFITS (Complete for employee only)

- |   |  |  |
|---|--|--|
| <b>Actual Date* of Change</b> _____ (*Last day worked/lost eligibility/retired, etc.)   | <b>Check applicable boxes below:</b><br><input type="checkbox"/> Waiving <b>dental</b> coverage (due to group coverage under a spouse or parent plan). Must submit a <b>Dental Waiver Form</b><br><input type="checkbox"/> No longer want <b>dental</b> coverage (subject to group participation requirements) | <input type="checkbox"/> Termination of employment (employee signature not required)<br><input type="checkbox"/> Retirement<br><input type="checkbox"/> Death (employee signature not required)<br><input type="checkbox"/> Leaving for active military service<br><input type="checkbox"/> Termination of Utah mini-COBRA or COBRA coverage |
| <input type="checkbox"/> Applying for Utah mini-COBRA**<br><input type="checkbox"/> Loss of eligibility (full to part-time, etc. but still employed)<br><input type="checkbox"/> Waiving <b>medical</b> coverage (due to group coverage under a spouse or parent plan). Must submit a <b>Medical Waiver Form</b><br><input type="checkbox"/> No longer want <b>medical</b> coverage (subject to group participation requirements) |  |  |

 \*\* (Six months of continuous group coverage through your current employer is required for Utah mini-COBRA. **Both employer and employee must sign this Change Form.**)

#### E. EMPLOYEE SIGNATURE

By signing, you agree to the changes requested above.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

#### F. EMPLOYER SECTION (Must be completed for all changes)

**Note:** If an employee is applying for COBRA coverage, proof of COBRA eligibility may be required. Employees applying for COBRA coverage must complete a separate COBRA Form. COBRA questions can be answered by calling 415-625-2481. COBRA forms can be obtained by calling 801-442-5615. **After completing this Change Form, return by faxing to 801-442-5798.**

Employer's Signature \_\_\_\_\_ Date \_\_\_\_\_

Company Name \_\_\_\_\_ Group# \_\_\_\_\_

Comments \_\_\_\_\_