



4646 West Lake Park Boulevard, Salt Lake City, UT 84120-8212 801-442-5038/800-538-5038 www.selecthealth.org

Small Employer Products NationCare Change Form

Employee Name _____ Subscriber# _____ Date of Birth _____

Employee Information Change

Name Changed From _____ Marital Status Change Marriage Divorced Death
 Name Changed To _____ Effective Date of Marital Change _____
 New Address _____ Unit/Apt# _____
 City _____ State _____ ZIP _____ New Ph# _____

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 SE Employee Application.

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

*Submit copy of adoption or placement papers

Delete Family Members

Delete Children

Last Name	First Name	Initial	Relationship	Effective Date (MM/DD/YY)	Reason
1.			Child		
2.			Child		
3.			Child		

Delete Spouse

Last Name	First Name	Initial	Relationship	Effective Date (MM/DD/YY)	Reason
1.			Spouse		<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 follow the steps below:

- 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 NationCare. 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.

Employee Termination/Discontinue Medical Benefits (complete for employee only)

Actual Date* of Change _____ (*Last day worked/lost eligibility/retired, etc.)

- (Check One)**

 - Termination of employment (employee signature not required)
 - Retirement
 - Death
 - Leaving for active military service

- Termination of Utah mini-COBRA or COBRA coverage
 - Applying for Utah mini-COBRA**
 - Loss of eligibility (full to part-time, etc. but still employed)

- Waiving coverage (due to group coverage under a spouse or parent plan only). Must submit a Waiver Form.
 - No longer want coverage

** (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.**)

Employee Signature

By signing, you agree to the changes requested above.

Employee's Signature _____ Date _____

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 Application Form. COBRA questions can be answered by calling 415-975-4600. 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 _____

Group Name _____ Group# _____

Comments _____