IHC HEALTH PLANS℠
IHC® A Service of Intermountain Health Care
PO BOX 30192 • SALT LAKE CITY • UTAH 84130-0192
Tel: 1-801-442-5038 • Toll Free: 1-800-538-5038

EMPLOYEE CHANGE FORM

EMPLOYEE NAME: ______________________ **SOCIAL SECURITY NUMBER:** ______________

■ EMPLOYEE INFORMATION CHANGE

NEW ADDRESS & PHONE NUMBER:

Street: ______________ City: ______________

State: ________ ZIP: ________ Phone: ______________

NAME CHANGE:

From: ______________

To: ______________

MARITAL STATUS CHANGE:

❑ Marriage ❑ Divorce ❑ Widow Change Date: ________

■ ADDITION OR DELETION OF FAMILY MEMBERS

	CHANGE	NAME (Last, First, Initial)	M/F	BIRTH DATE (MO / DAY / YR)	REASON
SPOUSE	❑ Add ❑ Delete			/ /	❑ Marriage ❑ Divorce[1] ❑ Loss of Other Coverage[3] ❑ Newborn ❑ Adoption ❑ Death
CHILD	❑ Add ❑ Delete			/ /	❑ Newborn ❑ Adoption ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Death ❑ Marriage ❑ Reached Limiting Age
CHILD	❑ Add ❑ Delete			/ /	❑ Newborn ❑ Adoption ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Death ❑ Marriage ❑ Reached Limiting Age
CHILD	❑ Add ❑ Delete			/ /	❑ Newborn ❑ Adoption ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Death ❑ Marriage ❑ Reached Limiting Age
CHILD	❑ Add ❑ Delete			/ /	❑ Newborn ❑ Adoption ❑ Divorce[1] ❑ Court Order[2] ❑ Loss of Other Coverage[3] ❑ Death ❑ Marriage ❑ Reached Limiting Age

NOTES:

1. **If you are making a change because of a divorce, you must attach a copy of the divorce decree with the Change Form. You should include the first page of the decree, the signature page, and any other portion(s) that specifies responsibility for dependent coverage.**
2. **If you are adding a dependent because of a Court or Administrative Order, please attach a copy with this form.**
3. **If you are making a change because of a Loss of Other Coverage, complete the information below.**

Carrier: ______________ Date Coverage Began: ________ Date Coverage Ended: ________

Carrier: ______________ Date Coverage Began: ________ Date Coverage Ended: ________

You must give proof of prior coverage to the IHC Health Plans within 60 days.

■ DISCONTINUANCE OF MEDICAL BENEFITS

❑ I wish to discontinue my medical benefits.

❑ I wish to discontinue my spouse's medical benefits. A copy of the divorce decree (see Note 1 above) must be attached, or the spouse's signature is required below.

Reason for Discontinuance: ______________ **Date of Discontinuance:** ________

Subscriber's Signature: ______________ **Date:** ________

Subscriber's Spouse's Signature: ______________ **Date:** ________

(Only required if a copy of the divorce decree is not provided.)

EMPLOYEE SIGNATURE

X ______________________ **DATE:** ________

■ EMPLOYER USE

Employer Authorization: ______________ Date: ________

Company Name: ______________

Group Number: ______________

Comments: ______________

DISCONTINUANCE OF MEDICAL BENEFITS

❑ Date of Termination: ________

❑ Date of Loss of Eligibility Status: ________

❑ Transfer: Date: ________ From: ________ To: ________

❑ Date of Retirement: ________

❑ Date of Death: ________

❑ Leaving for Active Military Service: ________

LEAVE OF ABSENCE

❑ Taking a Leave of Absence Date: ________ Expected Return Date: ________

❑ Return from a Leave of Absence Date: ________

Describe the Coverage Option Selected (as described in the Master Group Contract)

____