IHC HEALTH PLANS℠
IHC® A Service of Intermountain Health Care

PO Box 30192
Salt Lake City, UT 84130-0192

IHC Personal Managed Care Plans
CHANGE FORM

Subscriber's Name:	Subscriber ID #: (Located on your ID Card)	Date of Birth / /

■ SUBSCRIBER INFORMATION CHANGES

Name Changed From: Marital Status Change: ❒ Marriage ❒ Divorce ❒ Death

Name Changed To: Effective Date of Marital Change:

New Address: Unit/Apt. #:

City: State: ZIP: New Telephone Number: ( )

■ ADD FAMILY MEMBERS

Use this section only to add newborn, adopted children, or children placed for adoption. Application must be made within 31 days from the child's date of birth, adoption, or adoption placement.

ADDITION

NEWBORN OR ADOPTED CHILD

	LAST NAME	FIRST NAME	INITIAL	SEX	RELATIONSHIP	DATE OF BIRTH (MO/DAY/YR)
1.					❒ Natural ❒ Adopted*	/ /
2.					❒ Natural ❒ Adopted*	/ /

*Submit copy of placement or adoption papers

■ DELETE FAMILY MEMBERS

DELETION CHILD(REN)

	LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	DATE OF TERMINATION	REASON
1.				CHILD	/ /	
2.				CHILD	/ /	
3.				CHILD	/ /	

DELETION SPOUSE

SPOUSE MUST READ AND SIGN

	LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	EFFECTIVE DATE	REASON
1.				SPOUSE	/ /	❒ Death ❒ Annulment* ❒ Divorce*

** Divorce or Annulment*

If you are dropping coverage for your spouse as a result of a recent divorce or annulment, please follow the steps outlined below.

❒ **If you have family coverage:** You must submit the first and last pages 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 health care coverage through IHC Health Plans, Inc.

Spouse's Signature: _____ Date: _____

■ BENEFIT CHANGES

Benefit changes, other than those listed below, require the submission of an application. **All changes are subject to underwriting approval.** Deductible **cannot** be lowered using this Change Form.

Increase Deductible Level*

❒ $500 ❒ $2,500

❒ $1,000 ❒ $3,000

❒ $2,000

Change Plan* to:

❒ Yes, change my policy to a "Base-Level" plan

❒ Yes, change my policy to a "Mid-Level" plan

***Not all options may be available on your plan.**

Please contact your agent to verify which options are available to you. Requested effective date of change: _____

Any corresponding Rx deductibles and Rx out-of-pocket maximums will be adjusted accordingly. Refer to your contract for these amounts.

■ DISCONTINUANCE OF MEDICAL BENEFITS

❒ I hereby request the discontinuance of medical benefits received under Contract by IHC Health Plans, Inc. I understand that the discontinuance will be effective on the last day of the month following receipt and approval of this request by IHC Health Plans, Inc. Furthermore, I understand that *no cancellation will be made on a retroactive basis.*

❒ I wish to discontinue my medical benefits because I am leaving for active military service.

■ SIGNATURE

By signing, you agree to the changes requested above. To terminate coverage, please mark the discontinuance of medical benefits box above before signing.

Subscriber Signature: Date: