Medicare Supplement/SELECT Enrollment Change Form

PO Box 91110
Sioux Falls, SD 57110
(605) 328-6800
1-800-752-5863
sanfordhealthplan.com

Member Name_____________________________ **Member ID #:**_________________ **Change effective date:** ____/____/____

Reason for Requested Change (check all that apply):

❒ **Snowbird Travel Benefit** (Complete Section A)
❒ **Change in Benefit Package** (Complete Section A)
❒ **Name Change** (Complete Section B)
❒ **Address Change** (Complete Section C)
❒ **Cancel Coverage** (Complete Section D)
❒ **Other**____

Section A. Change of Benefit Package/Type:

Switching Plans: This form can be used to switch plans if you have guarantee issue rights or are in your open enrollment period. If you do not have guarantee issue rights or are not in your open enrollment period you must complete a new Medicare Supplement Application Form.

Snowbird Policy: This form can be used to switch from your SELECT Plan to the equivalent Standard Supplement Plan (with no network limitations) for up to 6 months. You will be charged the Standard Medicare Supplement rate during this time. Upon your return back to the service area, please complete this form again to switch back to the SELECT plan to receive the SELECT premium rates.

Are you currently a tobacco user or have you used tobacco in the past 3 years? ❒ Yes ❒ No

South Dakota and Iowa Residents

I would like to change from:	**To:**
❒ SELECT Plan A	❒ SELECT Plan A
❒ SELECT Plan C	❒ SELECT Plan C
❒ SELECT Plan F	❒ SELECT Plan F
❒ Standard Plan A	❒ Standard Plan A
❒ Standard Plan C	❒ Standard Plan C
❒ Standard Plan F	❒ Standard Plan F
❒ Standard Plan F High Ded.	❒ Standard Plan F High Ded.

Minnesota Residents

I would like to change from:	**To:**
❒ SELECT Extended Basic	❒ SELECT Extended Basic
❒ SELECT Plan Basic	❒ SELECT Plan Basic
❒ Basic Supplement	❒ Basic Supplement
❒ Part A Deductible Rider	❒ Part A Deductible Rider
❒ Part B Deductible Rider	❒ Part B Deductible Rider
❒ 100% Part B Excess Rider	❒ 100% Part B Excess Rider
❒ Extended Basic Supplement	❒ Extended Basic Supplement

NOTE: Please see your Outline of Benefits; switching plans may result in different health benefits and a different monthly premium. We will notify you by letter how this change affects your premium or benefits.

Section B. Name Change (Marriage/Divorce)

Former Name:____New Name:____

Section C. Address Change

New Address:____

New Telephone Number:__________________________________**NOTE:** If you have moved outside of the Sanford SELECT Service Area, we will send you a letter notifying you of your guaranteed issue rights to purchase other Medicare Supplement insurance.

Section D. Cancellation of Coverage

Reason for Cancellation:

❒ Have other coverage (list company name):____
NOTE: Cancellations become effective the 1st of the month following the Plan's receipt of this form.

❒ Eligible for Medicaid/State Assistance ❒ Death ❒ Other____

Signature

____
Member Signature Date Signed

____
Authorized Representative Signature (if applicable) Printed Name Relation Date Signed

For Agent Use Only:

____
Agent Name ID# Phone # Date Signed

For Internal Use Only:

Date Entered: ____________

Initials: _________________

Disbursement: White – Health Plan; Yellow – Agent; Pink - Applicant