Children's Health Insurance Program (CHIP)
health plan selection form

Utah Department of Health & Human Services

Once you have chosen a health plan, mail or fax this form to you're a DHHS Health Program Representative (HPR). Or email chiphpr@utah.gov with your plan choice and the information below. **(Please print clearly.)**

Case #		
Name of parent/guardian	(first name, last name)	Date of birth
Name(s) of child/children	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
	(first name, last name)	Date of birth
Contact information	(address, city, state, zip)	
	(daytime phone)	(cell phone)
	(email address)	
My choice of health plan	☐ **Select Health** ☐ **Molina** ☐ **Healthy U**	

Note: You must stay with your selected health plan through June 30 of each year.

Return to:

Mail: BMHC CHIP HPR, PO Box 143108
SLC, UT 84114-3108
Fax: 801-538-6099
Email: chiphpr@utah.gov