



Change Form

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www.AveraHealthPlans.com

TO BE COMPLETED BY EMPLOYER

Employer Name: _____
Group Number: _____
Subscriber Name: _____
Subscriber Number: _____

Please forward to Avera Health Plans upon completion to allow timely processing of request.

PLEASE COMPLETE APPLICABLE ITEMS

Name Change: From: _____ To: _____

Reason for change: _____ Requested Effective Date: _____

Address Change: (New) Mailing Address: _____

City, State, Zip: _____ County: _____

Phone Number: _____ Requested Effective Date: _____

Addition of NEWBORN or NEWLY ADOPTED Dependent(s): Must be submitted to Avera Health Plans within thirty (30) days after birth or placement of adopted child.

Dependent Name Social Security Number Gender (M/F) Birth Date (Mo/Day/Yr) Primary Care Physician

TERMINATION REQUEST

Avera Health Plans MUST receive written notification prior to the termination date for any voluntary terminations for the Subscriber and/or Dependents. (For example, any termination other than leaving employment or reduced hours.)

Termination of Subscriber Coverage: **Last Day of Coverage:** _____

What date did this event happen? _____

Leaving Employment Reduced Hours Other Coverage

Other (note reason): _____ Terminating Coverage Voluntarily (Still Employed)

Termination of Dependent(s) Coverage: **Requested Last Day of Coverage:** _____

What date did this event happen? _____

NOTE: A Subscriber may not terminate spousal coverage without the signed, informed consent of the spouse.*

Dependent(s): _____

Reason: _____

I, the undersigned, hereby give my informed consent to be terminated from dependent spouse coverage under Avera Health Plans. I understand that the termination date with Avera Health Plans will be the last day of the month in which termination was requested or the last day of the month in which this form is received by Avera Health Plans, whichever is later.

* Spouse Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Your signature is required and verifies that you acknowledge all information provided on this form is complete and true.

Employer Representative Signature (Required): _____ Date: _____