Change Form for Individual Health Insurance

Marketplace members must call 1-800-318-2596 to make account changes.

REQUIRED INFORMATION

Please complete this form using blue or black ink and send to Avera Health Plans along with any other required documents requested.

Subscriber Name on Member ID Card: _____

Subscriber Number: _____ Today's Date: _____ / _____ / _____

NOTE: After completing your change request, please sign and date page 3. Your signature is required to process any change.

☐ NAME CHANGE

From: _____ To: _____

Effective Date: _____ / _____ / _____ Reason for Name Change: _____

Required: Please provide a copy of the legal document supporting the name change requested.

☐ ADDRESS CHANGE AND/OR PHONE NUMBER CHANGE

Street Address: _____ Effective Date: _____ / _____ / _____

City: _____ State: _____ ZIP Code: _____

County: _____

Home Phone: (_____) _____ – _____ Work Phone: (_____) _____ – _____

☐ BENEFIT OPTION CHANGE (Grandfathered plans only)

A benefit option can only be cancelled after it has been in effect for 12 consecutive months. There is a 12-month waiting period to reapply for the canceled benefit option. Benefit option(s) will be cancelled automatically when you terminate your benefit plan.

☐ Preventive Vision Benefit Option

	Add	Cancel
Name: _____	☐	☐
Name: _____	☐	☐
Name: _____	☐	☐
Name: _____	☐	☐

☐ Preventive Dental Benefit Option

	Add	Cancel
Name: _____	☐	☐
Name: _____	☐	☐
Name: _____	☐	☐
Name: _____	☐	☐

☐ Add Maternity Benefit Option

This benefit applies to all females insured on the plan. To receive benefits from this Benefit Option, you must NOT be pregnant at the time of purchase. All deliveries within 9 months of the effective date will be reviewed to determine benefit eligibility. Consideration will be made for premature births during the review process.

Name: _____

☐ Currently pregnant ☐ Not pregnant

Name: _____

☐ Currently pregnant ☐ Not pregnant

☐ Cancel Maternity Benefit Option

☐ COVERAGE ELECTION CHANGE

GRANDFATHERED/TRANSITIONAL PLANS

☐ **ADDITION OF NEWBORN OR ADOPTED CHILD(REN)**
This signed form must be received within 31 days after an eligible dependent child's birth or placement for adoption (effective date will be the date of birth or date of placement for adoption). For adoption, you must also submit a copy of the adoption placement papers.

NOTE: If this form is not received within 31 days of the event, your child will be subject to medical underwriting and you will need to follow the requirements for Adding New Dependent(s).

☐ **ADDING NEW DEPENDENT(S)**
Adding new eligible dependents requires completion of an Avera MyPlan Enrollment Application. Please contact Avera Health Plans to obtain the appropriate enrollment application for your Benefit Plan. The added dependents will be subject to medical underwriting.

AFFORDABLE CARE ACT PLANS

☐ **ADDITION OF NEWBORN OR ADOPTED CHILD(REN)**
This form must be received within 60 days after an eligible dependent child's birth or placement for adoption (effective date will be the date of birth or date of placement for adoption). For adoption, you must also submit a copy of the adoption papers.

☐ **ADDING NEW DEPENDENT(S)**
New dependents must have a qualifying life event to be added to an existing plan. This form must be received within 60 days of that qualifying life event. You must also submit documentation proving the qualifying life event.

Please Add Newborn or Adopted Child: _____ ☐☐☐-☐☐-☐☐☐☐
(Legal Last Name, First Name, Middle Initial) Social Security Number

Gender: ☐ Male ☐ Female Birth Date: _____ / _____ / _____ or Adoption Date: _____ / _____ / _____

Please Add Newborn or Adopted Child: _____ ☐☐☐-☐☐-☐☐☐☐
(Legal Last Name, First Name, Middle Initial) Social Security Number

Gender: ☐ Male ☐ Female Birth Date: _____ / _____ / _____ or Adoption Date: _____ / _____ / _____

Are any of the dependents listed above eligible for Medicare / Medicaid? ☐ Yes ☐ No

If Yes, Name: _____ Medicare or Medicaid # _____

Name: _____ Medicare or Medicaid # _____

Are any of the dependents listed above covered under another health policy after the effective date with Avera Health Plans? ☐ Yes ☐ No If Yes, you must provide the following information to coordinate benefits:

Person Insured: _____ Employer of Insured: _____

Name of Insurance Company: _____ Policy Number: _____

List covered dependents: _____ Effective Date: _____ / _____ / _____

☐ TOBACCO USE STATUS CHANGE

☐ I, _____, have stopped using tobacco on _____ / _____ / _____ . I have been tobacco-free and
(Person Insured) have not used tobacco cessation products for 6 months.

☐ I, _____, started using tobacco on _____ / _____ / _____ .
(Person Insured)

Signature of person insured: _____ Date: _____ / _____ / _____

☐ TERMINATION OF COVERAGE

We must receive this form prior to your requested Termination Date. The termination date with Avera Health Plans will be the last day of the month in which this signed form is received by us. You will be responsible for any premiums through the date of termination.

☐ **Requested Termination Date for Subscriber:** _____ / _____ / _____
NOTE: You must complete a new Avera *MyPlan* Enrollment Application if you wish to continue coverage for eligible dependents.

☐ **Requested Termination Date for Dependent(s):** _____ / _____ / _____

List Dependent Name(s): _____

☐ **Notification of Deceased Member.** Date of Death: _____ / _____ / _____

Name of Deceased Member: _____
NOTE: Proof of decease is required. Please provide a copy of the death certificate.

☐ **Notification of Medicare Eligibility.** Date of Eligibility: _____ / _____ / _____

SIGNATURE REQUIRED TO PROCESS YOUR CHANGE REQUEST(S)

By signing the Avera *MyPlan* Change Form, I acknowledge that all information provided on this form is complete and accurate to the best of my knowledge. Avera Health Plans must receive this form within 15 days of the signature date.

Subscriber Signature: _____ Date: _____ / _____ / _____

After completed and signed, please submit to Avera Health Plans:

Fax: 1-605-322-4689
Email: ahpenrollment@avera.org

Or Mail:

Avera Health Plans, Enrollment Dept
5300 S. Broadband Ln
Sioux Falls, SD 57105-6538

Avera Health Plans

Phone: 605-322-4545
Toll Free: 1-888-322-2115
AveraHealthPlans.com