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.

NOTE: Eligible dependents under the age of 19 are not subject to medical underwriting during the open enrollment period as defined by the State of South Dakota.

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

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

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): _____

NOTE: You cannot cancel your spouse's coverage without your spouse reading the statement and signing below:

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

Spouse Signature: _____ Date: _____ / _____ / _____

☐ **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: 1-866-574-2217 (toll free)
Email: Sales@AveraHealthPlans.com

Or Mail:

Avera Health Plans, Enrollment Dept
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

Avera Health Plans

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

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
Avera Health Plans
3816 S. Elmwood, Suite 100,
Sioux Falls, SD 57105-6538

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Avera Health Plans

Getting Help in other Languages

Language assistance services are available free of charge. Our Service Center is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- US CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-322-2115 (رقم هاتف الصم والبكم: 1-800-877-1113.
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ. နမၤနဲ့ ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢၤ နီတမံၤဘဉ်သ့နူဉ်လီၤ. ကိး:1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (TTY: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113)
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113)
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-322-2115 (TTY: 1-800-877-1113)។