Avera Health Plans

Change Form

Medicare Supplement Insurance Policy

Policyholder name on Avera ID card: _____

Policy number on Avera ID card: _____

____ **Name Change**

From: _____ To: _____

Effective Date: _____ Reason for Name Change: _____

Please check all that apply and complete the required information that follows:

_____ **Address Change** due to moving and/or

_ _ **Address Change** for billing purposes (please send my invoice to):

Street address: _____

City: _____ State: _____ ZIP: _____

Effective date: _____

_____ **Phone Number Change**

Home phone: _____ Work phone _____

Effective date: _____

Termination of Coverage

____ Voluntary termination, reason for canceling policy: _____

Date of termination: _____ Terminations will be effective the first of the month following the termination date requested or the date this notice is received by Avera Health Plans, whichever is later.

____ Return policy, I am returning the policy within the 30-day, free-look period. If the policy has already become effective, please refund my premium and reverse the claim payments as if my policy was never purchased. Policy return date: _____

_____ Notification of deceased policyholder. Date of death: _____

NOTE: Copy of death certificate is required in order to terminate the policy.

Contact name: _____ Relationship to deceased policyholder: _____

Contact's day phone: _____

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

Policyholder Signature *(Required)*: _____ Date: _____

Mail to Avera Health Plans, Attn: Enrollment, 5300 S Broadband Ln, Sioux Falls, SD 57108-2221 or fax to 605-322-4689. You may send it electronically by email to ahpenrollment@avera.org
Our Customer Care Team is available Monday through Friday at 605-322-4545 or toll-free at 888-322-2115