Avera Health Plans

EMPLOYER NAME: _____

GROUP NUMBER: _____

EFFECTIVE DATE OF CHANGE: _____

OPEN ENROLLMENT CHANGE FORM

NOTE: If you are a recent new hire or not currently enrolled in medical benefits, **STOP**, you must complete an Enrollment Application. *Please ask your employer for this form.*

Please complete this form if you are currently enrolled for medical benefits.

Employee Name: _____ Member # _____

Has your mailing address changed? ☐ Yes ☐ No **If yes, please provide information below.**

Street or Mailing Address _____

City _____ State_____ZIP_____ County_____

Home Phone _____Email Address_____

Do you want to change your medical benefits? ☐ Yes ☐ No If yes, please select the Medical Plan below.
Medical Plan Selection:

☐ PLAN _____ ☐ PLAN _____
☐ PLAN _____ ☐ PLAN _____

Do you want to add your dependents to the Plan? ☐ Yes ☐ No If yes, please furnish the information below.
(If more space is needed, attach an additional sheet of paper, sign and date it.)

Legal Last Name, First Name MI	Gender M/F	Relationship* to Employee	Date of Birth MM/DD/YYYY	Social Security Number	Address if Different than Employees

*Eligible dependents are defined only as married spouse and natural dependent children, stepchildren, adopted children or children under legal custody who are within the limiting age. If your children are between the ages of 19 and 26 and have access to Employer Sponsored Health Coverage, please notify your employer.

NOTE: If you want to terminate coverage for yourself or any dependent, you must complete a Termination of Coverage Form. Please ask your employer for this form.

_____ _____
Signature of Employee (required) Date Signed

_____ _____
Signature of Employer (required) Date Signed