Avera Health Plans

TO BE COMPLETED BY EMPLOYER
Employer Name: _____
Group Number: _____
Subscriber Name: _____
Subscriber Number: _____

Change Form

Please complete the following and deliver to your Human Resources Department to process your request.

To whom do these changes apply? _____ Self _____ Other (name) _____

_____ **NAME CHANGE REQUEST**

From: _____ To: _____

Effective Date: _____ Reason for Name Change: _____

_____ **ADDRESS CHANGE REQUEST**

Street Address _____

City: _____ County: _____ State: _____ ZIP: _____

Effective Date: _____

_____ **PHONE NUMBER CHANGE REQUEST**

Telephone: _____ Work: _____

Effective Date: _____

Subscriber Signature: _____ **Date:** _____

TO BE COMPLETED BY EMPLOYER

The following must be completed by an authorized employer group representative.

Date: _____

Name/Completed By *(please print):* _____

Telephone: _____

Employer Signature: _____

Email Address: _____

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