3816 S Elmwood Avenue, Suite 100
Sioux Falls, SD 57105
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Toll-Free: 1 (888) 322-2115
www.AveraHealthPlans.com

Individual Change Form for Avera *MyPlan*

Please complete the items you want to change and send this form to Avera Health Plans.

Policyholder Name: ________________________________ Date: ____________________

Policyholder Number: ________________________________

❑ **Name Change**: FROM: __________________________ TO: __________________________

Reason for change: __________________________ Requested Effective Date: ______________

❑ **Address Change**: (NEW) Mailing Address: ____

City, State, ZIP: __________________________ County: __________________________

Phone Number: __________________________ Requested Effective Date: ______________

❑ **Plan Change**: Current Plan #: ____________________ Requested Effective Date: ____________________

TO: _______ Plan #1 ($1,500 deductible) _______ Plan #2 ($3,000 deductible) _______ Plan #3 ($5,000 deductible)

_______ Plan #4 ($2,000 deductible) _______ Plan #5 HSA Qualified ($2,500 deductible)

You must complete an application if you change to a plan with a lower deductible. Call the Service Center at 1 (888) 322-2115 for an application.

❑ **Option Change**: Requested Effective Date: ____________

Add	Delete		Add	Delete	
❑	❑	Vision	❑	❑	Preventive (Preventive may only be added to plans 3 and 5.)
❑	❑	Dental		❑	Maternity (You need to complete an application to add maternity. Maternity coverage is subject to medical underwriting.)

❑ **Tobacco Status Change**: ❑ Yes or ❑ No, I have not used any tobacco or tobacco cessation products during the 12 months before the date of this form.

❑ **Payment Change**: Current Payment Plan (monthly, quarterly, semi-annual or annual): ____________________

TO: ❑ Monthly ❑ Quarterly ❑ Semi-annual ❑ Annual

❑ **Adding Newborn or Adopted Child(ren)**: This form must be sent to us within thirty (30) days after your baby is born or the start of your adoption bonding period. Any other new dependents must be added with an application.

Name	Social Security Number	Gender (M/F)	Birth Date (Mo/Day/Yr)

❑ **Ending Coverage**: You **must** submit this form to Avera Health Plans **before** the date you want to end coverage.

❑ Policyholder **Requested** Effective Date: ____________________

❑ Dependent(s) **Requested** Effective Date: ____________________

Name(s): ____

You cannot cancel your spouse's coverage without your spouse signing this form.

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

Spouse Signature: ________________________________ Date: ____________________

Policyholder Signature: ________________________________ Date: ____________________

By signing this change form, you acknowledge that all information provided on the form is complete and true.