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

Change Form

Please forward to Avera Health Plans upon completion to allow timely processing of request.

PLEASE COMPLETE APPLICABLE ITEMS

Name Change: From: To:
Reason for change: Requested Effective Date:

Address Change: (New) Mailing Address:
City, State, ZIP: County:
Phone Number: Requested Effective Date:

Addition of NEWBORN or NEWLY ADOPTED Dependent(s):
Complete information below and submit to Avera Health Plans within thirty (30) days after birth or placement of adopted child.
Dependent Name Social Security Number Gender (M/F) Birth Date (Mo/Day/Yr) Primary Care Physician

**Avera Health Plans MUST be notified in writing prior to the date to end coverage for any voluntary terminations for the Subscriber and/or Dependents. (i.e. Any termination other than Leaving Employment or Reduced Hours.)

Termination of Subscriber Coverage: Last Day of Coverage:
What date did this event happen?
Leaving Employment Reduced Hours
Other Coverage Other (note reason):

Termination of Dependent(s) Coverage: Requested Effective Date:
What date did this event happen?
*A Subscriber may not cancel spousal coverage without the signed, informed consent of the dependent spouse.
Dependent(s):
Reason:

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:

Employee Signature: Date:
Your signature verifies that you acknowledge that all information provided on the change form is complete and true.

Employer Representative Signature (Required): Date: