Change Form for Individual Health Insurance

Marketplace members must call 1-800-318-2596 to make account changes.

(DT-115)

REQUIRED INFORMATION

Please complete this form using blue or black ink and send to Avera Health Plans along with any other required documents requested.

Subscriber Name on Member ID Card: ____

Subscriber Number: ______________________ Today's Date: _______ / _______ / _______

NOTE: After completing your change request, please sign and date page 2. Your signature is required to process any change.

☐ NAME CHANGE

From: ______________________________ To: ______________________________

Effective Date: _______ / _______ / _______ Reason for Name Change: ______________________

☐ BIRTHDATE CORRECTION

Name: ______________________________ Birthdate: _______ / _______ / _______

☐ ADDRESS CHANGE AND/OR PHONE NUMBER CHANGE

Street Address: ______________________________ Effective Date: _______ / _______ / _______

City: ______________________________ State: __________ ZIP Code: ______________

County: ______________________________

Home Phone: (______) ________ – ____________ Cell Phone: (______) ________ – ____________

☐ TOBACCO USE STATUS CHANGE

☐ I, ____________________, have stopped using tobacco on ______ / ______ / ______ . I have been tobacco-free and
(Person Insured) have not used tobacco cessation products for 6 months.

☐ I, ____________________, started using tobacco on ______ / ______ / ______ .
(Person Insured)

Signature of person insured: ______________________________ Date: ______ / ______ / ______

☐ TERMINATION OF COVERAGE

We must receive this form prior to your requested Termination Date. The termination date with Avera Health Plans will be the last day of the month in which this signed form is received by us. You will be responsible for any premiums through the date of termination.

☐ **Requested Termination Date for Subscriber:** _______ / _______ / _______

☐ **Requested Termination Date for Dependent(s):** _______ / _______ / _______

List Dependent Name(s): ____

☐ **Notification of Deceased Member.** Date of Death: _______ / _______ / _______

Name of Deceased Member: ____

NOTE: Proof of decease is required. Please provide a copy of the death certificate.

☐ **Notification of Medicare Eligibility.** Date of Eligibility: _______ / _______ / _______

SIGNATURE REQUIRED TO PROCESS YOUR CHANGE REQUEST(S)

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

Subscriber Signature: ____ Date: _______ / _______ / _______

After completed and signed, please submit to Avera Health Plans:

Fax: 1-605-322-4689
Email: ahpenrollment@avera.org

Or Mail:

Avera Health Plans, Enrollment Dept
5300 S. Broadband Ln
Sioux Falls, SD 57105-6538

Phone: 605-322-4545
Toll Free: 1-888-322-2115
AveraHealthPlans.com