

Avera MyPlan Change Form

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 3. Your signature is required to process any change.

NAME CHANGE

From: _____ To: _____

Effective Date: _____ / _____ / _____ Reason for Name Change: _____

ADDRESS CHANGE AND/OR PHONE NUMBER CHANGE

Street Address: _____ Effective Date: _____ / _____ / _____

City: _____ State: _____ ZIP Code: _____

County: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

BENEFIT PLAN ELECTION CHANGE

Effective Date*: _____ / _____ / _____ Avera *MyPlan* \$5,000 Avera *MyPlan* \$5,000 with Co-Pay

*Actual effective date will be the 1st of the month following receipt of this signed form.

BENEFIT OPTION CHANGE

A benefit option can only be canceled after it has been in effect for 12 consecutive months. There is a 12-month waiting period to reapply for the canceled benefit option. Benefit option(s) will be cancelled automatically when you terminate your benefit plan.

Preventive Vision Benefit Option

Name: _____

Name: _____

Name: _____

Name: _____

Add Cancel

Add Maternity Benefit Option

This benefit applies to all females insured on the plan. To receive benefits from this Benefit Option, you must NOT be pregnant at the time of purchase. All deliveries within 9 months of the effective date will be reviewed to determine benefit eligibility. Consideration will be made for premature births during the review process.

Name: _____

Currently pregnant Not pregnant

Name: _____

Currently pregnant Not pregnant

Preventive Dental Benefit Option

Name: _____

Name: _____

Name: _____

Name: _____

Add Cancel

Cancel Maternity Benefit Option

COVERAGE ELECTION CHANGE

ADDITION OF NEWBORN OR ADOPTED CHILD(REN)

This signed form must be received within 31 days after an eligible dependent child's birth or placement for adoption (effective date will be the date of birth or date of placement for adoption). For adoption, you must also submit a copy of the adoption placement papers.

NOTE: If this form is not received within 31 days of the event, your child will be subject to medical underwriting and you will need to follow the requirements for Adding New Dependent(s).

ADDING NEW DEPENDENT(S)

Adding new eligible dependents requires completion of an Avera MyPlan Enrollment Application. Please contact Avera Health Plans to obtain the appropriate enrollment application for your Benefit Plan. The added dependents will be subject to medical underwriting.

NOTE: Eligible dependents under the age of 19 are not subject to medical underwriting during the open enrollment period as defined by the State of South Dakota.

Please Add Newborn or Adopted Child: _____

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 (Legal Last Name, First Name, Middle Initial) Social Security Number

Gender: Male Female Birth Date: ____ / ____ / ____ or Adoption Date: ____ / ____ / ____

Please Add Newborn or Adopted Child: _____

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 (Legal Last Name, First Name, Middle Initial) Social Security Number

Gender: Male Female Birth Date: ____ / ____ / ____ or Adoption Date: ____ / ____ / ____

Are any of the dependents listed above eligible for Medicare / Medicaid? Yes No
 If Yes, Name: _____ Medicare or Medicaid # _____
 Name: _____ Medicare or Medicaid # _____

Are any of the dependents listed above covered under another health policy after the effective date with Avera Health Plans? Yes No If Yes, you must provide the following information to coordinate benefits:

Person Insured: _____ Employer of Insured: _____
 Name of Insurance Company: _____ Policy Number: _____
 List covered dependents: _____ Effective Date: ____ / ____ / ____

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 12 months.

I, _____, started using tobacco on ____ / ____ / ____ . (Person Insured)

Signature of person insured: _____ Date: ____ / ____ / ____

CHANGE IN MEDICAL CONDITION(S) — RATE-UP OR EXCLUSIONARY RIDER REVIEW

Please list medical condition(s) you would like reviewed and attach any supporting information from your physician(s):

Avera MyPlan Change Form continued

PAYMENT OPTION CHANGE — Please Choose One Option

If you are planning to use a business account to pay for your Avera *MyPlan* premiums, please answer the questions below:

1. Are there other employees in addition to you? Yes No
2. Will your premium payments for this coverage be deducted on your federal income tax return in a manner other than the special health insurance deduction available to self-employed persons? Yes No

If you answered "Yes" to either question above, premiums cannot be withdrawn from a business account. You will need to use a personal bank account to pay your premiums.

Automatic Account Withdrawal (New or Change)

If you select this payment option, then you must complete an Avera *MyPlan* Authorization for Automatic Account Withdrawal (EFT/ACH) Form and enclose a voided check or savings deposit slip showing a pre-printed account number, your name and the name and address of your financial institution.

NOTE: Automatic withdrawals are processed on or about the fifth day of every month. If the fifth is on a weekend or holiday, the automatic withdrawal will be processed on the next business day.

- Payment by Check.** Please cancel my authorization for automatic withdrawal. NOTE: We must receive this signed form at least 20 calendar days before your next scheduled withdrawal.

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:** _____ / _____ / _____

NOTE: You must complete a new Avera *MyPlan* Enrollment Application if you wish to continue coverage for eligible dependents.

- Requested Termination Date for Dependent(s):** _____ / _____ / _____

List Dependent Name(s): _____

NOTE: You cannot cancel your spouse's coverage without your spouse reading the statement and signing below:

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

Spouse Signature: _____ Date: _____ / _____ / _____

- Notification of Deceased Member.** Date of Death: _____ / _____ / _____

Name of Deceased Member: _____

SIGNATURE REQUIRED TO PROCESS YOUR CHANGE REQUEST(S)

By signing the Avera *MyPlan* 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 fax the form to 1 (866) 574-2217 (toll free)
or e-mail to AveraMyPlan@AveraHealthPlans.com.**



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