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.

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

Home Phone: (_______) _______ - __________ Work Phone: (_______) _______ - __________

Effective Date: ______________________

Subscriber Signature *(Required)*: ____ Date: _____________________

TO BE COMPLETED BY EMPLOYER
The following must be completed by an authorized employer group representative.

Date: ______________________

Name/Completed By: *(please print)*: ____________________________________ Phone: (_____) ______ - _________

Employer Signature: _____________________________ Email Address: _______________________________________

Please fax completed form to (605) 322-4689 or mail to:

Avera Health Plans
Attn: Enrollment Department
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

If any questions, please call our Service Center at **(605) 322-4545** or toll-free **1 (888) 322-2115**, 8 a.m. to 5 p.m. CT, Monday through Friday.