elite1
An Individual Sanford Health Plan Product

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • 1-800 752-5863
Fax: (605) 328-6812
sanfordhealthplan.com

REQUEST TO REVIEW AN AMENDMENT

Use this form to request a review of amendment(s) offered by Sanford Health Plan on your elite1 individual health insurance application.

Primary Applicant's Name:_____

Address: _____

Please list each applicant's name and the reason for the review:

Applicant Name	I am requesting a review of:	Which health condition would you like reviewed?	Reason for review?
	☐ Rider ☐ Rate-Up		
	☐ Rider ☐ Rate-Up		
	☐ Rider ☐ Rate-Up		
	☐ Rider ☐ Rate-Up		
	☐ Rider ☐ Rate-Up		
	☐ Rider ☐ Rate-Up		

Confirmation

Individual Completing this Form:

_____

Name Date

❒ Applicant ❒ Health Plan
❒ Insurance Agent ❒ Great Plains Brokerage

Please mail to: Sanford Health Plan
Medical Underwriting Department
PO Box 91110
Sioux Falls SD 57109-1110

Fax to: (605) 328-6811

UW Receipt Date	Medical records	Rider/Rate-Up Decision	Underwriting Completion Date	Date of Notification	Member Svs Complete date	Monthly Premium Rate
	Request Date: Rcpt Date:					

For UW purposes: