



## OUT-OF-AREA DEPENDENT CHILD NOTIFICATION

This dependent child notification form for out-of-area dependents is required when dependent children live outside the service area.

**TO ENSURE ACCURATE CLAIMS PAYMENT, THIS FORM MUST BE COMPLETED AND MAILED TO:**

**SENTARA HEALTH PLANS  
ATTN: ENROLLMENT DEPT.  
PO BOX 66189  
VIRGINIA BEACH, VA 23466  
Fax: 757-963-0205  
Email: [members@sentara.com](mailto:members@sentara.com)**

Group Number: \_\_\_\_\_

Group Name: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Product: \_\_\_\_\_

**YOUR COMPLETE NAME:**

**SOCIAL SECURITY NUMBER:**

\_\_\_\_\_

\_\_\_\_\_

Enter the name(s) and address(es) of your eligible dependents who are out-of-area:

Dependent 1

Name \_\_\_\_\_  
SSN \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_

Dependent 2

Name \_\_\_\_\_  
SSN \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_

Dependent 3

Name \_\_\_\_\_  
SSN \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_