Sentara® Health Plans

OUT-OF-AREA DEPENDENT CHILD NOTIFICATION
For use with the Out-of-Area Dependent Program

This form is required for dependent children living outside of the Sentara Health Plans service area.

TO ENSURE ACCURATE CLAIMS PAYMENT, THIS FORM MUST BE COMPLETED AND RETURNED TO YOUR HUMAN RESOURCES DEPARTMENT.

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 _____