OptimaHealth

OUT OF AREA DEPENDENT CHILD NOTIFICATION

For use with Out of Area Dependent Program

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

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

Group No. _____ **Group Name**:_____**Member No**. _____

Eff. Date of Coverage: _____ PRODUCT: _____

YOUR COMPLETE NAME **SOCIAL SECURITY NUMBER**

_____ _____

Last Name First MI

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

Dependent 1

Name _____
SSN _____
DOB _____
Address _____
City, State, Zip _____
Telephone _____

Dependent 2

Name _____
SSN _____
DOB _____
Address _____
City, State, Zip _____
Telephone _____

Dependent 3

Name _____
SSN _____
DOB _____
Address _____
City, State, Zip _____
Telephone _____