# 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 ______________________________________________

Revised 8.10.18