Out-of-Area Dependent Coverage Verification Form

Employer Name: Halifax Health (VHN Premier EPO Plan) **Group Number:** W14

Your HPI medical benefits plan includes in-network coverage, through the PHCS Out of Area and the MultiPlan Complementary provider networks, for eligible plan dependents living outside of the local service area.

To verify that your plan dependent(s) are living out-of-area — and to enable them to receive in-network coverage — you must complete and submit this form within 30 days of your eligible dependent(s) moving outside of your plan's service area. ***You must re-verify the status of each out-of-area dependent annually thereafter.*** Please refer to your Plan Document for full details and limitations.

Please submit your verification form(s) to HPI:

By Mail:	By Fax:	By Email:
Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581	508-795-1933	EnrollmentMailbox@HealthPlansInc.com

EMPLOYEE INFORMATION

Name: _____ **Member ID#:** _____

DEPENDENT(S) INFORMATION

Please note that each dependent will receive a new member ID card at the address provided below.

Name: _____

Address: _____

City: _____ **ST:** _____ **ZIP Code:** _____

This is a: ☐ Permanent Address

☐ Temporary Address: *From:* _____ *To:* _____

Name: _____

Address: _____

City: _____ **ST:** _____ **ZIP Code:** _____

This is a: ☐ Permanent Address

☐ Temporary Address: *From:* _____ *To:* _____

Name: _____

Address: _____

City: _____ **ST:** _____ **ZIP Code:** _____

This is a: ☐ Permanent Address

☐ Temporary Address: *From:* _____ *To:* _____

EMPLOYEE SIGNATURE

Signature: _____ **Date Signed:** _____

*For more information about your plan, call HPI's Member Services team at **866-393-2303**, weekdays from 8:00AM to 5:00PM (ET), or contact us online at **MyVHN.com**; just click on **Contact**.*