

ElevateHealth Out-of-Area Dependent Coverage Verification Form

Your plan provides limited coverage for eligible dependent children under the age of 26 who live outside of New Hampshire and Vermont (the enrollment area). To make use of this benefit, you must complete and submit this form during your Open Enrollment period, or within 30 days of your eligible dependent child moving outside the enrollment area, and then annually thereafter. Please refer to your Summary Plan Description for full benefit details and limitations. Forms may be submitted to Health Plans, Inc. via fax, email, or mail (contact information is located at the bottom of this form).

MEMBER INFORMATION

Name: _____ Member ID #: _____

DEPENDENT(S) INFORMATION

Please note that your dependent will receive a new member ID card at the address provided below to use when out of area.

Name: _____ Address: _____ City: _____ State: _____ Zip: _____	This is a: <input type="checkbox"/> Permanent Address <input type="checkbox"/> Temporary Address* From: ____/____/____ To: ____/____/____
Name: _____ Address: _____ City: _____ State: _____ Zip: _____	This is a: <input type="checkbox"/> Permanent Address <input type="checkbox"/> Temporary Address* From: ____/____/____ To: ____/____/____
Name: _____ Address: _____ City: _____ State: _____ Zip: _____	This is a: <input type="checkbox"/> Permanent Address <input type="checkbox"/> Temporary Address* From: ____/____/____ To: ____/____/____

* Please specify the span of time your child will be residing at this address

MEMBER SIGNATURE

Signature: _____ Date: _____

For more information about your plan, visit healthplansinc.com/d-h
 or call 866-471-5550, Monday through Friday from 8:00 am to 5:00 pm

Please submit this form to Health Plans, Inc.:
 Fax: 508-795-1933 | Email: enrollmentmailbox@healthplansinc.com
 Mail: Health Plans, Inc. · P.O. Box 5199 · Westborough, MA 01581