PIEDMONT COMMUNITY
HEALTH PLAN

**OFFICE USE ONLY**

**NETWORK:** _____

# Out-Of-Area Dependent Registration Form

**This benefit is available to all fully insured and some self-insured members.**
**Please check with your employer to confirm availability.**

- **Subscriber Name:** _____
- **Subscriber ID#:** _____
- **Subscriber Employer Company Name:** _____

  Or, if you are covered by an Individual Marketplace Policy, check here: ☐
- **Out-of-area Dependent Name:** _____
- **Out-of-area Dependent Date of Birth:** _____
- **Address of Out-of-Area Dependent:** _____

  _____
- **Name of College/University Attending (if applicable):** _____

  _____
- **Address of College/University (if applicable):** _____

***Please submit this form along with your enrollment form or within 30 days prior to start of coverage to:***

**Enrollment Department**
**Piedmont Community Health Plan**
**2316 Atherholt Road**
**Lynchburg, VA 24501**

**Fax: 434-845-1850**
**Phone: 434-947-4463, 800-400-PCHP**