Health Alliance℠

College Extended Network Program

Out-of-Area Coverage for College Students

Health Alliance gives your family access to top-notch doctors and hospitals. That doesn't have to change when your student goes away to college.

Through our College Extended Network Program, dependent children on your plan who leave our service area to attend a college, university, technical school or vocational school can get access to the national PHCS Healthy Directions and MultiPlan networks while in school.

Your dependent college student will receive a special ID card and can search the PHCS Healthy Directions and MultiPlan networks through **YourHealthAlliance.org.**

All other family members on the plan will keep their current ID cards and will use the standard provider network.

It's easy to sign your student up for extended coverage at no extra cost.

1. Fill out the attached form and turn it in to your human resources department.
2. Give your child the new ID card we send you.
3. Turn in a new form each year that your child is in school (you'll get a reminder when it's time).

If you have questions, call the Customer Service number on the back of your ID card.

College Extended Network Program Verification

Primary Subscriber/Plan Participant Name: _____

Primary Subscriber/Plan Participant 11 Digit Member Number:

9	4	0							–		

Dependent Name: _____

Dependent 11 Digit Member Number:

9	4	0							–		

Dependent SSN:

			–			–				

Dependent Birth Date (MM/DD/YYYY): _____

Dependent Address at Academic Institution (Address/City/State/Zip):

_____

Academic Institution Name: _____

Academic Institution Address (Address/City/State/Zip):

_____

Start Date of Classes (MM/YYYY): _____

End Date of Classes (MM/YYYY): _____

I hereby verify that my above-mentioned dependent is considered a full-time student by the academic institution he/she attends and is eligible for dependent coverage under my Health Alliance-administered plan. I further agree to provide evidence of this fact as may be requested by Health Alliance. I understand that such a request may be made at any time while coverage is in effect under this plan.

I understand that benefits available to the above-mentioned dependent are subject to all other plan provisions and limitations. I further understand there is a 90-day minimum (consecutive days) out-of-area requirement to qualify for extended network coverage.

I further understand I am responsible for re-applying for this extended network coverage annually.

Primary Subscriber/Plan Participant Signature: _____

Date: _____

HR Manager—Please submit this document to Health Alliance in one of the following ways:
Fax: 217-337-8055
Email: Membership@HealthAlliance.org
Mail to: Health Alliance Medical Plans
Attn: Enrollment
301 S. Vine St.
Urbana, IL 61801