



DEPENDENCY QUESTIONNAIRE

INSTRUCTIONS: PLEASE COMPLETE FORM, SIGN AT THE BOTTOM AND RETURN TO:
BAC - ADMINISTRATION DEPARTMENT, PO BOX 107, REYNOLDSBURG, OH 43068-0107.

A. PLEASE COMPLETE THIS FORM ENTIRELY AND ATTACH ALL NECESSARY COURT ORDERS AND/OR TAX RETURNS.

EMPLOYEE'S NAME (LAST, FIRST, M.):		EMPLOYER'S NAME:	
FULL NAME OF CHILD (LAST, FIRST, M.):		CHILD'S D.O.B. (MM/DD/YYYY):	
CHILD'S RELATIONSHIP TO EMPLOYEE: <input type="radio"/> NATURAL CHILD <input type="radio"/> STEPCCHILD <input type="radio"/> ADOPTED CHILD <input type="radio"/> OTHER, PLEASE SPECIFY:			
DOES THE CHILD LIVE WITH YOU?: <input type="radio"/> NO <input type="radio"/> YES - IF YES, HOW LONG?			
IS THERE A COURT ORDER STATING THAT YOU, OR THE NATURAL FATHER/MOTHER, SHOULD PROVIDE MEDICAL BENEFITS FOR THE CHILD?: <input type="radio"/> NO <input type="radio"/> YES - IF YES, ATTACH A COPY OF THE COURT ORDER			
ARE YOU RESPONSIBLE FOR THE CHILD'S FINANCIAL SUPPORT AND MAINTENANCE?: <input type="radio"/> NO SUPPORT <input type="radio"/> YES, SOME SUPPORT <input type="radio"/> YES, MAJORITY OF SUPPORT			
DOES YOUR DEPENDENT CHILD QUALIFY AS AN EXEMPTION ON YOUR FEDERAL INCOME TAX RETURN? IT IS NOT NECESSARY THAT YOU CLAIM THIS DEPENDENT CHILD ON YOUR FEDERAL INCOME TAX FILING, ONLY THAT THIS DEPENDENT CHILD MEETS THE DEFINITION OF AN ELIGIBLE DEPENDENT FOR FEDERAL INCOME TAX PURPOSES. <input type="radio"/> NO <input type="radio"/> YES			
IS THE CHILD COVERED UNDER ANY OTHER GROUP PLAN?: <input type="radio"/> NO <input type="radio"/> YES - IF YES, PROVIDE THE FOLLOWING INFORMATION ▼			
NAME AND RELATIONSHIP (TO THE CHILD) OF THE PERSON CARRYING COVERAGE:			
NAME OF EMPLOYER:		NAME OF INSURANCE COMPANY:	
POLICY NUMBER:		TYPE OF COVERAGE: <input type="radio"/> MEDICAL <input type="radio"/> DENTAL <input type="radio"/> VISION	

PLEASE USE THE BACK SIDE OF THIS FORM IF THE CHILD HAS MORE THAN ONE OTHER GROUP PLAN COVERAGE

B. AUTHORIZATIONS:

Always contact BAC's Administration Department if you have questions regarding your child's eligibility for coverage. It is the employee's responsibility to notify the employer or BAC when a dependent child is losing his/her eligibility for coverage. It is important to notify us immediately, because COBRA continuation coverage is usually available when the employee notifies the employer or BAC within 60 days of a child losing eligibility.

I, _____ hereby certify that the above is true and correct.

EMPLOYEE'S SIGNATURE

DATE SIGNED (MM/DD/YYYY): _____

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.