CERTIFICATION OF STUDENT ENROLLMENT

bac

INSTRUCTIONS: PLEASE COMPLETE THIS FORM AND SUBMIT TO:
BAC – ATTN: ADMINISTRATION DEPT., PO BOX 107, REYNOLDSBURG, OH 43068-0107, OR FAX TO 614.863.9137, OR EMAIL TO BACADMIN@BACTPA.COM

A. PLEASE COMPLETE THIS FORM ENTIRELY

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:

◯ **NATURAL CHILD** ◯ **STEPCHILD** ◯ **ADOPTED CHILD** ◯ **OTHER, PLEASE SPECIFY:**

IS DEPENDENT CHILD MARRIED?

◯ **NO** ◯ **YES** **IF YES, DATE OF MARRIAGE:**

STUDENT I.D. NUMBER:

NAME OF SCHOOL OR UNIVERSITY:

ADDRESS OF SCHOOL OR UNIVERSITY: CITY: STATE: ZIP CODE:

ATTENDING:

◯ **FULL-TIME** ◯ **PART-TIME**

PROJECTED DATE OF GRADUATION AND/OR COMPLETION OF STUDY:

PRESENT TERM OF ENROLLMENT (MM/DD/YYYY):

START DATE: / / **FINISH DATE:** / /

IF DEPENDENT IS NO LONGER A STUDENT, LAST DAY IN SCHOOL:

IS DEPENDENT EMPLOYED?:

◯ **FULL-TIME** ◯ **PART-TIME**

DEPENDENT'S EMPLOYER NAME:

IS CHILD COVERED UNDER ANY OTHER MEDICAL INSURANCE?

◯ **NO** ◯ **YES**

NAME OF OTHER INSURANCE COMPANY:

POLICY HOLDER'S NAME (LAST, FIRST, M.):

INSURANCE I.D. NUMBER:

IS THIS COVERAGE THROUGH?

◯ **STUDENT – FULL MEDICAL** (THROUGH COLLEGE OR UNIVERSITY)
◯ **STUDENT – ACCIDENT ONLY** (THROUGH COLLEGE OR UNIVERSITY)
◯ **GROUP** (THROUGH AN EMPLOYER)
◯ **INDIVIDUAL** (OTHER THAN THOSE PREV. LISTED)

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. (Example: No longer a full time student or becomes married.) 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):

MAIL COMPLETED FORM TO BAC:
ATTN: ADMINISTRATION DEPT.
PO BOX 107 REYNOLDSBURG, OH 43068

OR FAX COMPLETED FORM TO BAC AT:
(614) 863-9137

OR EMAIL COMPLETED FORM TO BAC AT:
BACADMIN@BACTPA.COM

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.