ADULT DEPENDENT CHILD QUESTIONNAIRE

INSTRUCTIONS: PLEASE COMPLETE FORM, SIGN AT THE BOTTOM AND RETURN TO:
BAC - ADMIN. DEPT, PO BOX 107, REYNOLDSBURG, OH 43068-0107 – 1.800.521.2654

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 STATE OF RESIDENCE:

ADULT CHILD'S RELATIONSHIP TO EMPLOYEE:
◯ **NATURAL CHILD** ◯ **STEPCHILD** ◯ **ADOPTED CHILD** ◯ **OTHER, PLEASE SPECIFY:**

IS THE CHILD EMPLOYED:
PART-TIME: ◯ **YES** ◯ **NO** **FULL-TIME:** ◯ **YES** ◯ **NO**

ADULT CHILD'S MARITAL STATUS:
◯ **SINGLE** ◯ **MARRIED** ◯ **DIVORCED** ◯ **WIDOWED**

IF EMPLOYED, NAME OF EMPLOYER:

EMPOYER'S PHONE NUMBER:

IF EMPLOYED, EMPLOYER'S ADDRESS:

IS YOUR ADULT CHILD ELIGIBLE FOR COVERAGE UNDER THEIR EMPLOYER'S HEALTH BENEFIT PLAN?
◯ **YES** ◯ **NO**

IS YOUR ADULT CHILD A FULLTIME STUDENT AT AN ACCREDITED COLLEGE OR UNIVERSITY?
◯ **YES** ◯ **NO**

IS THE CHILD COVERED UNDER ANY OTHER MEDICAL GROUP PLAN?:
◯ **NO** ◯ **YES – IF YES, PROVIDE THE FOLLOWING INFORMATION** ▼

MEDICAL COVERAGE IS PROVIDED BY:
◯ **ADULT CHILD'S EMPLOYER** ◯ **PARENT'S EMPLOYER:** ◯ **CHILD'S SPOUSE'S EMPLOYER:**

NAME OF INSURANCE COMPANY:

POLICY NUMBER:

EFFECTIVE/START DATE:

IS THE CHILD COVERED UNDER ANY OTHER DENTAL GROUP PLAN?:
◯ **NO** ◯ **YES – IF YES, PROVIDE THE FOLLOWING INFORMATION** ▼

DENTAL COVERAGE IS PROVIDED BY:
◯ **ADULT CHILD'S EMPLOYER** ◯ **PARENT'S EMPLOYER:** ◯ **CHILD'S SPOUSE'S EMPLOYER:**

NAME OF INSURANCE COMPANY:

POLICY NUMBER:

EFFECTIVE/START DATE:

IS THE CHILD COVERED UNDER ANY OTHER VISION GROUP PLAN?:
◯ **NO** ◯ **YES – IF YES, PROVIDE THE FOLLOWING INFORMATION** ▼

VISION COVERAGE IS PROVIDED BY:
◯ **ADULT CHILD'S EMPLOYER** ◯ **PARENT'S EMPLOYER:** ◯ **CHILD'S SPOUSE'S EMPLOYER:**

NAME OF INSURANCE COMPANY:

POLICY NUMBER:

EFFECTIVE/START DATE:

B. SIGNATURE:

Always contact BAC's Administration Department if you have questions regarding your adult 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.