bac

DEPENDENCY QUESTIONNAIRE

INSTRUCTIONS: PLEASE COMPLETE THIS FORM AND EMAIL TO **BAC_ADMIN@BACTPA.COM**
OR, MAIL TO **BAC – ADMINISTRATION DEPT, 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:

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

DOES THE CHILD LIVE WITH YOU?:

◯ **NO** ◯ **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?:

◯ **NO** ◯ **YES – IF YES, ATTACH A COPY OF THE COURT ORDER**

ARE YOU RESPONSIBLE FOR THE CHILD'S FINANCIAL SUPPORT AND MAINTENANCE?:

◯ **NO SUPPORT** ◯ **YES, SOME SUPPORT** ◯ **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.

◯ **NO** ◯ **YES**

IS THE CHILD COVERED UNDER ANY OTHER GROUP PLAN?:

◯ **NO** ◯ **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:

◯ **MEDICAL** ◯ **DENTAL** ◯ **VISION**

◯ **PLEASE USE THE BACK (OR ADD AN ATTACHMENT) 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):

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:
BAC_ADMIN@BACTPA.COM

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.