ADULT DEPENDENT CHILD QUESTIONNAIRE

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 BAC_ADMIN@BACTPA.COM

A. PLEASE COMPLETE THIS FORM ENTIRELY:

EMPLOYEE'S NAME (LAST, FIRST, M.):

EMPLOYER'S NAME:

FULL NAME OF ADULT DEPENDENT CHILD (LAST, FIRST, M.):

CHILD'S D.O.B. (MM/DD/YYYY):

CHILD'S ADDRESS: CITY: STATE: ZIP CODE:

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

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

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

IF EMPLOYED, NAME OF EMPLOYER:

EMPLOYER'S PHONE NUMBER:

IF EMPLOYED, EMPLOYER'S ADDRESS: CITY: STATE: ZIP CODE:

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

IS THE ADULT DEPENDENT CHILD A FULL-TIME STUDENT AT AN ACCREDITED COLLEGE OR UNIVERSITY?
◯ **YES** ◯ **NO**

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

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

NAME OF INSURANCE COMPANY: POLICY NUMBER: EFFECTIVE/START DATE:

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

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

NAME OF DENTAL INSURANCE COMPANY: POLICY NUMBER: EFFECTIVE/START DATE:

NAME OF VISION INSURANCE COMPANY: POLICY NUMBER: EFFECTIVE/START DATE:

B. SIGNATURE:

Always contact BAC's Administration Department if you have any questions regarding your adult dependent child's eligibility for coverage. It is the employee's responsibility to notify either their employer or BAC when a dependent child loses his/her dependent status as COBRA continuation coverage may be available if notification is received within 60 days of their change in 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.