BENEFIT SERVICES™
A DIVISION OF MEDICAL MUTUAL SERVICES, LLC

Please return form to:
Attn: Eligibility Department
PO Box 4138
Akron, OH 44321

## YOUNG ADULT / ADULT CHILD CERTIFICATION

I hereby request coverage for my dependent child shown below.

Participant's Employer:____________________________________________________ Group Number:_________________________________

Participant's Name:________________________________________________________________________________________________________

Participant's Address:______________________________________________________________________________________________________
Number and Street City State Zip

## YOUNG ADULT / ADULT CHILD INFORMATION

Dependent's Name:_____________________________________________ Relationship to Participant:________________________________

Date of Birth:_____ / ______ / ______ Marital Status: ___ Single ___ Married ____ Divorced ___Separated

Address:_______________________________________________________________________________________________________________________
Number and Street City State Zip

Student: ____ Yes ______ No Number of Credit Hours: _________ Name of School:________________________________________

**Is this Dependent employed: _____ Yes _____ No**

Name and address of employer: ___________________________________________________________________________________________

Does this employer offer any health insurance for which this Dependent Child is eligible? ____Yes ____No

Is this Dependent Child covered under any other group medical insurance? _____ Yes ______ No

If yes, identify the other insurance carrier:_____________________________________________________________________________

Policy Number:__________________________________ Policyholder:_____________________________________________________

Is this Dependent Child eligible for Medicaid or Medicare? _____ Yes ______ No

<u>Signature of Participant</u>

I certify that all information provided in this form is correct to the best of my knowledge and authorize release of any information requested with respect to this Certification. I understand that Benefit Services at its sole discretion may rescind my coverage at any time on the basis of any untrue, inaccurate or incomplete answer to any question in this Certification, or any misrepresentation, omission or concealment on this Certification, whether intentional or otherwise. I further understand if coverage is issued, it will be issued in full reliance and in consideration of the information, answers and statements contained herein.

_____________________________________________________________________________________________ / ________________________
Signature of Participant Date

_____________________________________________________________________________________________ / ________________________
Signature of Dependent Date

**WARNING**: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.