



MEDICAL MUTUAL OF OHIO®
CAROLINA CARE PLAN | CONSUMERS LIFE

Please return form to:
Attn: Membership Department
Medical Mutual of Ohio
P.O. Box 943
Toledo, OH 43656-0001

ADULT DEPENDENT CHILD CERTIFICATION

I hereby request coverage with Medical Mutual, or one of its subsidiaries, for my dependent child shown below.

Certificate Holder's Employer: \_\_\_\_\_ Group Number: \_\_\_\_\_

Certificate Holder's Name: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

Certificate Holder's Address: \_\_\_\_\_
Number and Street City State Zip

ADULT DEPENDENT CHILD INFORMATION

Dependent's Name: \_\_\_\_\_ Relationship to Policyholder: \_\_\_\_\_

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

Signature of Certificate Holder

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 Medical Mutual, including any of its subsidiaries, 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 by Medical Mutual, or one of its subsidiaries, in full reliance and in consideration of the information, answers and statements contained herein.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Signature of Certificate Holder 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.