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 or insurance fraud.