



**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.