MUTUAL HEALTH SERVICES℠

Minor Eligibility Verification Form

Employer: _____
Employee: _____ ID #:
Regarding: _____

Relationship to Employee: Natural Stepchild Adopted Legal Ward

Dependent's Date of Birth: ___/____ /_____
Street Address: _____ City: _____ State _____ Zip _____

Section I:

Birth Mother's Name: _____ Date of Birth: ___/___ /_____
Birth Father's Name: _____ Date of Birth: ___/___ /_____
Are Birth Parents living together in the same residence or legally married to each other?
NO / YES-Married / Yes-Living Together
If answer is yes to the above question, please move on to section III.

Section II:

☐ Has either or both parents been ordered by the court to provide health coverage for this child?
Yes. If yes, you must include a copy of the filed court documents, as we are legally bound to follow their directive. Failure to do so may cause a delay in the processing of claims for this dependent.

☐ No. Indicate reason: (ex. other parent deceased, incarcerated, etc.)
_____
Who has physical custody of the child?

Section III:

Is this dependent covered under any other group medical insurance?
☐ No This dependent does not have any other insurance coverage.

☐ Yes If Yes: Policy Holder: _____ Relation: _____
Birthdate: __/ _____/_____ Insurance Carrier:
Eff Date: ___/ _____ /_____ Term Date: (if applicable) /
____ /_____ ☐ ☐ ☐ ☐
Please Indicate Type of Benefits: Med Rx Dental Vision

I certify 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 the plan sponsor, 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.

Participant
Signature: _____ Date: _____ / ____/_____

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

Please return this form completed either by:

- Fax: 330.666.3836;
- Email: MHSAdmin@MutualHealthServices.com; or
- Mail: Mutual Health Services, P.O. Box 5700, Cleveland, OH 44101

ADMINOR