BAC of MICHIGAN
Health and Welfare Fund
P.O. Box 99490 • Troy, MI 48099-9490 • Phone (248) 828-6000 • Fax (248) 828-6001

APPLICATION FOR COVERAGE OF DEPENDENT CHILD

(Please complete a separate form for each child)

To be completed by the Participant:

1. Your name: _____

2. Your Social Security Number: _____

3. Child's name: _____

4. Child's date of birth: _____

Please mark any of the following items that are applicable to your request for coverage, and attach the appropriate documents **(failure to attach the documents requested will result in delays in processing your application)**:

	YES	NO	
A.	{ }	{ }	The child is my natural child or adopted child. (Please attach a copy of a birth certificate or final adoption order.)
B.	{ }	{ }	The child has been designated as my dependent child in a Qualified Medical Child Support Order or National Medical Support Notice. (Please attach copies of the Qualified Medical Child Support Order or National Medical Support Notice.)
C.	{ }	{ }	The child has been placed in my home for adoption by me. (Please attach a copy of the placement for adoption order.)
D.	{ }	{ }	The child is my stepchild (the natural or adopted child of my spouse). (Please attach copies of your marriage certificate and the child=s birth certificate.)
E.	{ }	{ }	The child is my foster child. (Please attach proof of such relationship from the Michigan Department of Human Services.)
G.	{ }	{ }	The child **not** my natural or adopted child or the natural or adopted child of my spouse, **but** is otherwise related to me or my spouse, and neither of the child's parents are providing health care coverage for the child.

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If you marked "Yes" on item G. above, please answer the following:

1. Please describe how you or your spouse are otherwise related to the child (e.g., my grandchild, my spouse's niece):

   _____

2. Have you or your spouse been appointed the child's legal guardian?

   Yes____No____(If yes, please attach copies of the Letters of Guardianship, Acceptance of Appointment and, if applicable, your marriage certificate.)

3. If you or your spouse has been appointed the child's legal guardian, when was the date of the appointment?

   _____
   (Date)

4. Does the child reside in your household? **Yes____No ____**

5. Is any other person (such as either of the child's natural parents) legally responsible for providing health care coverage for the child?

   Yes ____ No ____

   If no, please explain why:

   _____

   _____

   _____

   If yes, please list all persons legally responsible for providing health care coverage for the child and their relationship to the child:

   _____

   _____

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Please also attach proof of that the persons listed above are legally responsible for providing health care, such as a Judgment of Divorce or National Medical Support Notice, and proof that the persons listed above are not providing coverage, such as the following:

a. Death certificate;
b. Proof of incarceration;
c. Proof of mental incapacity;
d. Proof of residence in a foreign country; or
e. Documents submitted in support of a petition for guardianship.

H. The child is over age 18 **Yes___No ___**

If you marked "Yes" on item H. above, please answer the following:

1. Is the child currently eligible to enroll under his/her employer-sponsored health plan? (Note: The Fund is not asking whether your child has in fact enrolled in his/her employer's plan; rather, is the child *eligible* to enroll?) **Yes___No ___**

   So that we may verify this information, please provide the name and contact information of your child's employer. If your child is currently unemployed, please so state:

   _____

   _____

2. Is the child married? **Yes___No ___**

3. If the child is married, is the child currently eligible to enroll in his/her spouse's employer-sponsored health plan? (Note: The Fund is not asking whether the child has in fact in enrolled in his/her spouse's employer's plan; rather, is the child *eligible* to enroll?) **Yes_____No ___**

   So that we may verify this information, please provide the name and contact information of the child's spouse's employer. If the spouse is currently unemployed, please so state:

   _____

   _____

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I,_____, hereby state that the information I have provided on this application form is correct to the best of my knowledge and belief. I understand that it is my responsibility to provide the Fund Office with any changes in the information I have provided herein, in writing, within 15 days of any such change, including any updated documentation. I understand that I will be required to reimburse the Fund for any claims that are paid on the basis of inaccurate information contained in my application due to my failure to notify the Fund within 15 days of the date such information becomes inaccurate.

Participant's Signature:_____Date: _____

Witness: _____ Date:
_____(Fund Office Personnel)