MEMBER LETTER

MEDICAL MUTUAL®

Medical Mutual®
2060 East Ninth Street
Cleveland, Ohio 44115-1355

MedMutual.com

08/15/2017

CANTON, OH 44721

Group Number: 418470
Dependent:

Dear Policyholder:

Our annual student recertification process confirms dependent eligibility for dental and/or vision plans. In order to continue processing dental and/or vision claims for your dependent student, please complete the enclosed form and return it to our office in the envelope provided by October 1, 2017. Failure to return the form by this date will result in the cancellation of your dependent's coverage effective August 1, 2017.

If you have any questions about this letter or the enclosed form, please contact Customer Care at the phone number indicated on the back of your identification card.

Sincerely,

Sue Miller
Director, Membership Services

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MEDICAL MUTUAL®

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.

Policy Holder's Employer: _____ Group number: _____

Policy Holder's Name: _____ Policy number: _____

Policy Holder's Address: _____
Number and Street City State ZIP

ADULT DEPENDENT CHILD INFORMATION

Dependent's Name: _____ Relationship to Policy Holder: _____

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: _____ Policy Holder: _____

Is this Dependent Child eligible for Medicaid or Medicare? ☐ Yes ☐ No

Signature of Policy 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 Policy 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.