Ohio Dependent Eligibility Questionnaire

Name of Primary Applicant: _____Certificate Number: _____

Name of Dependent: _____Relationship to Primary Applicant: _____

Please have the primary applicant circle the answer to each question below. The primary applicant must sign and date on the appropriate lines below and return this letter to Celtic Insurance.

1. Is the dependent named above a natural child, stepchild, or adopted child of the primary applicant? YES / NO
2. Is the dependent named above unmarried? YES / NO
3. Is the dependent named above currently a resident of Ohio or a full-time or part-time student at an accredited institution of higher education? YES / NO
4. Is the dependent named above employed by an employer that offers any health benefit plan under which he/she is eligible for coverage? YES / NO
5. Is the dependent named above eligible for coverage under the Medicaid or Medicare program? YES / NO

Primary Applicant's Signature: _____ Date: _____

Completed form may be mailed to:

Celtic Insurance Company
ATTN: Underwriting Department
PO Box 33640
Indianapolis, IN 46203-0640

FAX: 800-600-8802