Wisconsin 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 unmarried? YES / NO
2. Does the dependent named above have other health care coverage? YES / NO
3. Is the dependent named above employed fulltime and eligible for employer health care coverage? 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