Statement of Responsibility For A Dependent Child

For Coverage Underwritten by:
Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Exclusive Healthcare, Inc.

For DentaBenefits Plans Only:
United Concordia Insurance Company
United Concordia Dental Corporation of Alabama
United Concordia Life and Health Insurance Company
United Concordia Insurance Company of New York

Required for all foster children, stepchildren, grandchildren and adopted children (the form must be completed for <u>each</u> child)

1. Master Policy/Contract(s) _____, _____, _____, _____, _____

2. Employee's Name/Soc. Sec. Number _____ _____-____-_____
   Last First MI Social Security Number

3. Employee's Address_____
   Address City State Zip

4. Full Name of Child/Date of Birth_____ _____/_____/_____
   Last First MI Date of Birth

5. Does this child live in your home? ☐ Yes ☐ No
   If "Yes," is this ☐ Permanent or ☐ Temporary
   If "Yes," how long has this child lived in your home? _____

6. How long do you expect this child to continue living in your home?_____

7. Was this child placed in your home by the social service agency, which retains control of the child? ☐ Yes ☐ No
   If "Yes," is this ☐ Permanent or ☐ Temporary

8. Are you raising this child as your own? ☐ Yes ☐ No

9. Have you taken full parental responsibility and control of this child? ☐ Yes ☐ No

10. Is the child's natural parent(s) in a position to exercise or share parental responsibility and control? ☐ Yes ☐ No

11. Does anyone else share parental responsibility and control of this child? ☐ Yes ☐ No
    If "Yes," please provide their name(s) and their relationship to this child.
    _____ _____ _____ _____
    Full-name Relationship Full-name Relationship

12. Are you related to this child? ☐ Yes ☐ No If "Yes," please indicate below how you are related to this child.
    _____

13. Is this child chiefly dependent on you for support? ☐ Yes ☐ No
    If "Yes," is this child claimed as a dependent on your federal income tax return? ☐ Yes ☐ No

14. Who else provides support for this child? (Name and relationship below)
    _____ _____ _____ _____
    Full-name Relationship Full-name Relationship

15. Date this child was placed in your custody &/or home_____/_____/_____
    Month Day Year

16. Attached is the ENTIRE court order(s) or other documents for legal custody/guardianship/adoption for this child. ☐ Yes ☐ No

17. Provide the following information with respect to this child's natural parents:

	Full Name	Age/Date of Birth	Street Address	City	State/Zip	Occupation
Mother						
Father						

18. Does the child have coverage under any <u>other health plan</u> that you will retain if the child is enrolled in this health plan? ☐ Yes ☐ No
    If "Yes," please provide the following information about their other insurance coverage(s):

Primary Covered Individual	Name of Employer offering Other Insurance	Other Insurance Company Name and Address	Policy Number	Effective Date	Type of health coverage(s) (i.e. Group Medical, Group Dental, Medicare, Medicaid)

I attest that all the above answers are correct and complete and I will notify the applicable Insurance Company immediately of any changes.

_____ _____/_____/_____
Signature of Insured Person Date