

APPLICATION
FARMERS' ELECTRIC AREA YOUTH BENEFIT FUND

APPLICATION #: _____

Received: _____

Section 1

1. Name of Child: _____
(last) (first) (middle)

2. Residence of Child: _____
(street address) (city) (county) (zip)

Length of residency at this location: _____

3. Age: _____ Sex: _____ Birth Date: _____
(xx/xx/xx)

4. Name of Father: _____ Age: _____
(first) (middle) (last)

Address: _____
(street address) (city) (state) (zip)

Phone Number: _____

Marital Status (check one): single married separated divorced or widowed

5. Name of Mother: _____ Age: _____
(first) (middle) (last)

Address: _____
(street address) (city) (state) (zip)

Phone Number: _____

Marital Status (check one): single married separated divorced or widowed

6. Name of Legal Guardian if different from above: _____ Age: _____
(first) (middle) (last)

Address: _____
(street address) (city) (state) (zip)

Phone Number: _____

Marital Status (check one): single married separated divorced or widowed

7. Nature of illness or injury: _____
Date of illness or injury: _____

8. If child is in a hospital provide name and address of hospital: _____

If child is presently under doctor's care, please have the doctor complete Section III of this form. If child is not presently under doctor's care, give name, address and telephone number of physician who last treated the child:

(physician's name)

Address: _____
(street) (city/state/zip) (phone)

Section II

THIS SECTION TO BE COMPLETED BY APPLICANT'S PARENTS OR LEGAL GUARDIAN.

1. Number of dependent children _____ Ages: _____

Father/Legal Guardian

Mother

2. Name of Employer: _____

3. Address of Employer: _____

4. Date Employed: _____

5. Exact kind of work: _____
(check one) Full Time Part Time Full Time Part Time

6. Family taxable income according to last year's tax return:
 0 - \$15,000
 \$15,001 - \$25,000
 \$25,001 - \$45,000
 \$45,001 - up

7. Previous Employer: _____

8. How long employed: _____

9. Previous Salary: \$ _____ \$ _____

10. Do you rent your principal residence? _____ Monthly rental payment \$ _____

11. Do you own your own home? _____ Monthly mortgage payment \$ _____

12. Is your child covered by medical or hospitalization insurance? Yes No

13. If there is coverage by both parents' employers, indicate both companies:

a. Father's insurance company: Name of Company _____
Policy Number: _____

b. Mother's insurance company: Name of Company _____
Policy Number: _____

14. Do you presently owe for any medical treatment for this child not covered by insurance? *

Yes No

Indicate Amount: \$ _____

To Whom: _____

Address: _____

Indicate Amount: \$ _____

To Whom: _____

Address: _____

Indicate Amount: \$ _____

To Whom: _____

Address: _____

Indicate Amount: \$ _____

To Whom: _____

Address: _____

Indicate Amount: \$ _____

To Whom: _____

Address: _____

Indicate Amount: \$ _____

To Whom: _____

Address: _____

Indicate Amount: \$ _____

To Whom: _____

Address: _____

15. Have there been any other medical bills in the family recently? Yes No

For Whom: _____ Amount: _____

To Whom: _____

Address: _____

For Whom: _____ Amount: _____

To Whom: _____

Address: _____

15. (Cont.) Have there been any other medical bills in the family recently? Yes No

For Whom: _____ Amount: _____

To Whom: _____

Address: _____

For Whom: _____ Amount: _____

To Whom: _____

Address: _____

For Whom: _____ Amount: _____

To Whom: _____

Address: _____

For Whom: _____ Amount: _____

To Whom: _____

Address: _____

For Whom: _____ Amount: _____

To Whom: _____

Address: _____

16. Have you had other expenses, other than medical, pertaining to care for the child?

Please itemize (such as mileage, lodging, meals, etc. Use additional paper if necessary.)

17. Other efforts being made to raise necessary funds not covered by insurance:

18. Name of Fund established for child: _____

Mailing address of Fund: _____

I hereby certify that the foregoing statements are true and correct to the best of my knowledge.

Signature of Father

Signature of Mother

Signature of Legal Guardian
(if other than parents)

*** If requesting assistance with the payment of medical bills,
please send a copy of the current statement from the provider(s).**

Information contained in this application shall remain confidential.

Return completed application to:

**Farmers' Electric Area Youth Benefit Fund
Attn: Lacey Capps
201 W Business 36
Chillicothe MO 64601**

or email: lacey@fec-co.com

PHYSICIAN'S CERTIFICATE

Date: _____

Section III

- 1. Patient's Name _____
- 2. Describe injury or illness: _____

- 3. Remarks and recommendations: _____

- 4. Physician's Name (please print) _____
- 5. Physician's Address _____

- 6. _____
(Signature of Physician)

ACTION OF BOARD OF DIRECTORS

Date: _____ Approved: _____ Disapproved: _____

Amount of Contribution: \$ _____

Reason if Disapproved: _____

Signature _____

President of Board