

**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.)

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

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: Laura Schad  
201 W Business 36  
Chillicothe MO 64601**

**or email: [laura@fec-co.com](mailto:laura@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)

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**ACTION OF BOARD OF DIRECTORS**

Date: \_\_\_\_\_ Approved: \_\_\_\_\_ Disapproved: \_\_\_\_\_

Amount of Contribution: \$ \_\_\_\_\_

Reason if Disapproved: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_

President of Board