



AULTCARE USE ONLY							
EM	EAM	EDM	ENF	COBM	Date Completed	Completed By	Card Sent
EMPLOYER USE ONLY							
Group Name			Group Number		Location Code		
Coverage Type(s) Requested: (Check all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> RX <input type="checkbox"/> Vision					AultCare Effective Date		

**(1) COVERAGE INFORMATION**

Please Check Plan Type:  
 PPO    HMO    POS (Point of Service)    Other \_\_\_\_\_

A) NEW POLICY APPLICATION	B) CHANGE TO AN EXISTING POLICY
1. Reason for enrollment* <input type="checkbox"/> New Group <input type="checkbox"/> New Hire <input type="checkbox"/> Change in family/employment status (Complete all sections on application) Explain: _____	1. Date of Change: _____ 2. Requested Effective Date: _____ <input type="checkbox"/> Add a Child (Complete all sections on application)* Date of birth/adoption: _____ <input type="checkbox"/> Add a Spouse (Complete all sections on application)* Date of marriage: _____ <input type="checkbox"/> Change in Name or Address (Complete Section 2 and sign Section 5 as Eligible Employee) Former name: _____ <input type="checkbox"/> Deleting a Dependent from Policy (Complete Section 3 and sign Section 5 as Eligible Employee)

\*Upon your effective date with AultCare, please supply a letter of creditable coverage if applicable.

**COBRA SECTION**

Covered Under:    Cobra    State Continuation  
 Qualifying Event:    Termination/Retirement    Divorce    Reduction in Hours  
 No Longer Eligible    Other   Qualifying Event Date \_\_\_\_\_

**(2) EMPLOYEE INFORMATION**

Employee Last Name		First Name	Middle	Social Security Number	
Home Address (Number & Street)			County	Date of Birth	
City	State	Zip Code	Home Phone	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married (Date of Marriage) _____ <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated					
Employment Status		Date of Hire: _____	Are you currently actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Hours Worked per Week: _____		If no, why? _____			
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired					
Do you, or any of your dependents, have any cultural or linguistic needs? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what are they?					

**(3) EMPLOYEE/DEPENDENT INFORMATION**

A(dd) C(hange) D(elete)	Relationship	First Name	M.I.	Last Name (If different from employee)	Social Security Number	Sex M or F	Date of Birth
	Employee				/ /		/ /
	Spouse				/ /		/ /
	Spouse's Employer				/ /		/ /
	Child				/ /		/ /
	Child				/ /		/ /
	Child				/ /		/ /
	Child				/ /		/ /
	Child				/ /		/ /

Children age 26-27 must be residents of Ohio or attending an accredited college full-time, unmarried, not eligible for health benefits through an employer, not eligible for Medicare or Medicaid, and not in the armed forces or any foreign country to be eligible for coverage. Complete the section below for all children age 26-27.

Child's Name	College or University Name and Address	# of Credit Hours	Anticipated Date of Graduation

If any of your eligible children live at a different address from yours, please list: Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 If your spouse or any of your enrolled children are permanently disabled please provide their name(s): \_\_\_\_\_  
 Have you, your spouse, or any of your children submitted claims to AultCare in the past 12 months? \_\_\_\_\_  
 If yes, please list employer group name the claims were paid through: \_\_\_\_\_

As of your effective date with AultCare, will you or any of your family members have other health insurance?    YES    NO  
 If yes, what is the name of the other insurance company? \_\_\_\_\_  
 If yes, what type(s) of other health insurance will you have? (circle all that apply)   Medical   RX   Dental   Vision

**(4) MEDICARE INFORMATION**

Do you or your spouse or any enrolled dependents have Medicare coverage?    YES    NO   If yes, provide information below

Medicare Enrollee Name	Medicare ID#
Hospital Effective Date (Part A)	Medical Effective Date (Part B)

Do you have Medicare Part D Coverage?    YES    NO  
 If yes, what is the effective date of your Part D coverage? \_\_\_\_\_

**(5) SIGNATURES**

**Sign if Applicable to Your Plan:**  
 I authorize deduction from my wages, as necessary, for any required premium for the coverage for which I have applied.

\_\_\_\_\_  
**Your Signature**

\_\_\_\_\_  
**Date**