

Group #: _____ (Please refer to your AultCare ID card.) Actively Working
 Enrollee Name: _____ Retired date of retirement ___/___/___
 ID # _____ Disabled-Working Disabled-Not Working
 *****Please complete each part that applies to you and your dependents. Please print.*****

Part 1 ENROLLEE INFORMATION - All enrollees must complete.

Do you have coverage **OTHER** than this group # (listed above) where you are the policyholder?
 No ➡ Previous carrier termination date ___/___/___ (if within the last 24 months) ➡ **Part 2.**
 Yes ➡ Is **OTHER** coverage: Active plan Retiree plan Medicare ➡ **Part 3.**
 Insurance Name: _____ Group# _____ Effective Date: ___/___/___
 Current Company Name: _____ # of employees Less than 20 20-99 100+
 Who is covered under **OTHER** plan? _____
 Check coverage(s): MEDICAL DENTAL VISION PRESCRIPTION SUPPLEMENTAL HRA/HSA FLEXIBLE SPENDING

Part 2 SPOUSE INFORMATION - Complete, if married.

Spouse's name _____ Date of Birth ___/___/___ Date of Marriage ___/___/___
 Is spouse employed? No Yes ➡ Employer _____ # of employees: Less than 20 20-99 100+
 Does spouse have other coverage? No ➡ **Part 2b.** Yes ➡ **Part 2a.**

Part 2a SPOUSE WITH OTHER COVERAGE

Is spouse's coverage: Active plan Retiree plan Medicare ➡ **Part 3.**
 Policyholder's Name _____ ID# _____ Group # _____
 Insurance Name _____ Effective Date: ___/___/___
 Who is covered under spouse's plan? _____
 Check coverage(s): MEDICAL DENTAL VISION PRESCRIPTION SUPPLEMENTAL HRA/HSA FLEXIBLE SPENDING

Part 2b SPOUSE WITHOUT OTHER COVERAGE - Check reason

Prior coverage terminated: Termination date ___/___/___ Benefits not offered Unemployed Self employed
 Part time employee (not eligible for benefits) Waiting period Eligible for coverage ___/___/___
 Waived as of ___/___/___ Reason for waiving coverage: _____
 Other, please explain _____

Part 3 MEDICARE COVERAGE - Complete, if you or your dependents have MEDICARE coverage.

| | |
|---|---|
| Name of person covered by Medicare: _____ | Name of person covered by Medicare: _____ |
| Medicare # _____ | Medicare # _____ |
| Part A Effective Date ___/___/___ | Part A Effective Date ___/___/___ |
| Part B Effective Date ___/___/___ | Part B Effective Date ___/___/___ |
| Part D Effective Date ___/___/___ Term Date ___/___/___ | Part D Effective Date ___/___/___ Term Date ___/___/___ |
| Part D Carrier Name _____ | Part D Carrier Name _____ |
| Reason for Medicare coverage: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease (ESRD) Date dialysis treatment began ___/___/___ Date of kidney transplant ___/___/___ | Reason for Medicare coverage: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease (ESRD) Date dialysis treatment began ___/___/___ Date of kidney transplant ___/___/___ |

If you don't have children listed on this policy, skip Parts 4 & 5 and sign and date on Page 2.



**Other Coverage Information Form
(annual update required)**

Group #: _____ (Please refer to your AultCare ID card.)
 Enrollee Name: _____
 ID #: _____

Part 4 CHILDREN INFORMATION - Complete for all children covered under this group -# (listed above)

| Child's first and last name | Other Coverage? If no, provide termination date only if within 24 months | Insurance Name | Effective Date | Circle Coverage (see key below*) | Policyholder's first and last name & Relationship to Child |
|-----------------------------|---|----------------|----------------|----------------------------------|--|
| | <input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes → | | __/__/__ | M D V R S H F | |
| | <input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes → | | __/__/__ | M D V R S H F | |
| | <input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes → | | __/__/__ | M D V R S H F | |
| | <input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes → | | __/__/__ | M D V R S H F | |
| | <input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes → | | __/__/__ | M D V R S H F | |

*Coverage Type key: M=Medical D=Dental V=Vision R=Prescription S=Supplemental H=HRA/HSA F=Flexible Spending

Part 5 DIVORCED, LEGALLY SEPARATED or SINGLE PARENT - Complete, if you have child(ren) covered under this group#(listed above). Complete this part even if some of the information duplicates information provided in Part 4.

Note: If you have a divorce decree/court order which indicates who is responsible to provide healthcare coverage for your child (ren), please attach a copy. The required sections are:

- 1.) the first section, which lists the names of who the divorce decree/court order pertains to,
- 2.) the section which lists the child(ren) ,
- 3.) the section which includes the shared parenting/custody arrangements,
- 4.) the healthcare coverage section, and
- 5.) the last page with signature and stamped court file date.

If you have previously provided us with a copy of your divorce decree/court order AND there are no changes, you do not need to submit another copy.

Check the correct statement:

- I acknowledge that there are no changes to my divorce decree/court order that I previously submitted to AultCare.
- I have attached my divorce decree/court order with changes to this form.
- I have attached my divorce decree/court order for the first time to AultCare.

If there is more than one child and there is a different biological/adoptive parent, please check this box and provide all of the following information on the back of this page.

Child (ren)'s first and last names: _____

Child(ren)'s address _____

Name of other biological/adoptive parent _____ Date of Birth __/__/__

Address _____

Insurance Name _____ Effective Date __/__/__ Termination Date __/__/__

If the divorce decree/court order states the other parent is responsible, but the other parent does not have coverage for your child(ren), please check reason:

- Other parent is unemployed and unable to provide coverage for child (ren).
- Other parent's employer does not offer coverage.
- No knowledge of where other parent resides.
- Never married, no other coverage available.
- Other. Please explain on the back of this page.

SIGNATURE (Required)

I understand failure to provide adequate, complete and truthful information may result in the denial of claim payment(s). I hereby certify that the statements contained herein are true to the best of my knowledge.

Enrollee's Signature _____

Date _____

AULTCARE
 ATTN: COB
 P.O. BOX 6910
 CANTON, OH 44706
 330-363-6360 or 1-800-344-8858

Note: If any changes occur during the year, please notify the Service Center.