AULTCARE

APPLICATION FOR CONTINUATION OF COVERAGE

For a child who is incapable of self-sustaining employment by reason of mental or physical disability and who has reached the limiting age for dependent children specified in the plan or contract.

SECTION I – To be completed by employee

Dependent Child's Name Last | First | Middle Initial

Child's Sex ☐ Male ☐ Female | Child's Birth Date | Relationship to Employee

Employee's Name Last | First | Middle Initial

Identification Number | Group Number | Name of Employer

Employee's Address
Street | City | State | Zip Code

Employee Phone Number

Child's Marital Status
☐ Single ☐ Married ☐ Widowed ☐ Divorced | Date Child's Disability Occurred

Is the child permanently residing in your household? ☐ YES ☐ NO
If no, please explain.

Is the child dependent on you for support? ☐ YES ☐ NO
If yes, what part of support do you contribute? (indicate a percentage of the total)

Was the child taken as a dependent on your last income tax return? ☐YES ☐NO

Is the child employed now? ☐ YES ☐ NO | Was the child ever employed? ☐ YES ☐ NO

If the answer to either of the last two questions is 'yes,' please provide the name(s), address(es) of employer(s), and date(s) employed.

Is the dependent covered under any other health plan? ☐ YES ☐ NO | If yes, please provide the name and address of insurance company.

INSURANCE FRAUD WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I acknowledge that AultCare Insurance Company may use and disclose my protected health information, as well as, the protected health information of my family for payment, treatment, and operations. This information may be disclosed to other insurance companies, third party administrators, state and federal agencies, health care providers and other organizations and persons that perform professional, business, or insurance functions for AultCare, as permitted by state and federal law. The information may be used for, but not limited to, processing enrollment applications, risk classifications, detecting or preventing fraud, internal and external audits, claims administration, case management, quality improvement programs, public health reporting, law enforcement investigations, coordination of benefits, medical management programs, and subrogation.

Date | Signature of Employee | Social Security Number of Employee

Signature of Dependent or Authorized Individual | Relationship to Dependent

SECTION II – To be completed by attending physician

Dependent Child's Name Last	First	Middle Initial
Child's Sex ☐ Male ☐ Female	Child's Birth Date	Relationship to Employee

Employee's Name Last	First	Middle Initial

Identification Number	Group Number	Name of Employer

Employee's Address Street	City	State	Zip Code

Employee Phone Number

Has the child's disability existed continuously up to the present? ☐ YES ☐ NO

Date Child's Disability Occurred	Prognosis (Est. months or years)

Is the child now incapable of self-support because of the disability? ☐ YES ☐ NO

Nature of Disability (Please provide as much detail as practicable.)

What functional ability does this patient lack?

Mental	Physical

Why is this patient unable to work or maintain a full-time class status?

Complete diagnosis

How long has this member been under your care?	Date of last medical examination

Documented findings from last medical examination

Printed Name of Physician

Date

Signature of Physician

Physician's Address

Physician Phone Number

Physician Degree/Specialty

DEA #

Note: The length of time this authorization is valid can vary. The person or authorized representative is entitled to receive this form.

To physician: please return the form to AultCare Customer Service | PO Box 6910 | Canton, OH 44706