Guide for Completing the Enrollment Application/Change Form

Please complete this form in its entirety.

EMPLOYER USE ONLY

This section is to be completed by the employer representative.

Employer Group Numbers
List all AultCare group numbers that apply. (Medical, Dental, Vision)

Employee Location/Job Classification
Use this section to designate an employee classification, if needed. These designations should be set-up as rate codes during the implementation of your plan. (Example: hourly vs. salary; executive or management; physical plant location.)

Leased Network
Designate if the employee is accessing an out-of-area network. (Cigna, First Health Network, etc.)

AultCare Effective Date
Provide the date the coverage is set to begin.

EMPLOYEE COVERAGE ELECTION

This section is to be completed by the employee.

A) NEW POLICY APPLICATION

☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Waiving Coverage
Designate the reason for applying for coverage or if coverage is being waived. If waiving coverage, a signature is required on the back of this form.

☐Qualifying Event – Explain:
If applying for coverage for a qualifying event, please provide a detailed explanation. (For example: spouse lost coverage, marriage, birth, adoption.)

Hire Date
If the original hire date is not available, please provide the month and year.

Coverage Type(s) Requested:
Check All that Apply ☐Medical ☐Dental ☐Rx ☐Vision ☐STD ☐Life ☐Flex ☐HSA ☐HRA
Be sure to check all benefit options being elected.

Plan Requested: Plan Name
Use this section to designate the employee's plan election. (Example: PPO, HDHP or OPT 1, OPT 2, etc.)

ADDITIONAL COVERAGE FOR DEPENDENTS

This section is to be completed by the employee.

A(dd), C(hange), D(elete)
Please provide the reason code for enrolling or disenrolling dependents.

Social Security Number
SSN are required for all dependents with coverage.

Benefits Selected (M,D,V,R)
List all that apply.

Other Insurance Coverage? (Y/N)
If yes, please complete the other coverage information on the back of this form.

OTHER COVERAGE INFORMATION

This section is to be completed by the employee if any covered persons have other health insurance coverage.

MEDICARE INFORMATION

This section is to be completed by the employee if any covered persons are enrolled in Medicare.

OTHER INFORMATION

This section is to be completed by the employee to designate any specified needs.

All Employees
Signature_____ Date _____
Employee must sign and date when electing coverage.

Employees Waiving Coverage
Reason for waiver of coverage: _____
Employee and spouse must provide reason for waiving coverage.
Signature_____ Date _____
Employee and spouse must sign if either are waiving coverage.

Please submit this form to AultCare by one of the following methods:
Email: aultcareeligibility@aultcare.com | Fax: 330-363-7746 | Mail: AultCare Member Services PO Box 6910 Canton, OH 44706
Employer to send completed form to AultCare by one of the following methods.

AULTCARE