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.