

Enrollment Application/Change Form

without Medical Questions

AULTCARE USE ONLY	
Date Completed	Completed By
Card Sent	

EMPLOYER USE ONLY		
Employer Name	Employer Group Numbers	
Employee Location/ Job Classification	Leased Network <input type="checkbox"/> Yes <input type="checkbox"/> No	AultCare Effective Date

EMPLOYEE COVERAGE ELECTION	A) NEW POLICY APPLICATION <input type="checkbox"/> New Group <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Waiving Coverage <input type="checkbox"/> You Only <input type="checkbox"/> You & Your Spouse <input type="checkbox"/> You & Your Child(ren) <input type="checkbox"/> You, Your Spouse & Your Child(ren) <input type="checkbox"/> Qualifying Event – Explain: _____				Date of Qualifying Event _____ (Qualified enrollment must be made within 31 days of event)	
	B) EMPLOYEE INFORMATION		Last Name	First Name	Middle Initial	Suffix
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number			
	Home Address (Number & Street)		County	City	State	Zip Code
	Preferred Phone Number	Email Address	Primary Care Physician Name (HMO Only)			
	Marital Status <input type="checkbox"/> Married – Date of Marriage _____			<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	Currently on Hire Date	Hours Worked Per Week	Are you currently actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, why? _____		
	Coverage Type(s) Requested: Check All that Apply <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision <input type="checkbox"/> STD <input type="checkbox"/> Life <input type="checkbox"/> Flex <input type="checkbox"/> HSA <input type="checkbox"/> HRA			Plan Requested: Plan Name _____		

ADDITIONAL COVERAGE FOR DEPENDENTS	A(dd), C(hange), D(elete)	Relationship to Enrollee	First Name	M.I.	Last Name (If different from employee)	Social Security Number	Benefits Selected (M,D,V,R)	Gender (M or F)	Date of Birth	Other Insurance Coverage? (Y/N)

M - Medical D - Dental V - Vision R - Prescription

IMPORTANT INFORMATION

OTHER COVERAGE INFORMATION	Upon your effective date with this plan, will you or any of your family members have other health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If yes, what is the name of the other insurance company?
	If yes, what type(s) of other health insurance will you have? Check all that apply <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision

MEDICARE INFORMATION	Do you or your spouse or any enrolled dependents have Medicare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO			If yes, please provide information below.	
	Medicare Enrollee Name	Medicare ID Number	Hospital Effective Date (Part A)	Medical Effective Date (Part B)	
	Do you have Medicare Part D coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what is the effective date of your coverage?			

OTHER INFORMATION	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?

RELEASE OF INFORMATION/PLEASE READ CAREFULLY

I am applying for group health coverage through AultCare Insurance Company and its related entities ("AultCare"). I acknowledge the coverage for which I am applying is subject to eligibility requirements and the terms of the policy. I acknowledge that I have read and understood all of the information contained within this document. Additionally, I acknowledge that all information that I have entered in this application, to the best of my knowledge, is complete, true, and accurate. I understand that any attempt to mislead or defraud AultCare is considered insurance fraud.

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 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.

All Employees

I have read all of the statements contained in this application and declare that by signing this application the information I have provided is true and complete to the best of my knowledge. Electronic Signature Disclaimer: Please be advised that AultCare will not deny the enforceability or effect of an electronic signature solely because it is in an electronic format. Any valid signature provided in this section shall have the same legal effect and enforceability as a manually executed signature. I authorize deduction from my wages, as necessary, for any required premium for the coverage for which I have applied.

Signature _____ Date _____

Employees Waiving Coverage

I have read all of the statements contained in this application and declare by signing that the information I have provided is true and complete to the best of my knowledge. I understand that I am eligible to apply for coverage through my employer. And I acknowledge that, subject to the terms and conditions of the policy, by waiving coverage at this time, I may not be able to enroll myself or my family again until the next annual enrollment period or a special enrollment period. I hereby decline coverage for (check all that apply): Myself Spouse Child(ren)

Reason for waiver of coverage: _____

Signature _____ Spouse Signature _____ Date _____

Per the 2015 FTC TCPA, AultCare or a vendor of AultCare, may contact you for demographic, satisfaction, and/or medical care management information in accordance with its obligation under Federal Law.

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



CANTON REGIONAL... CHAMBER
HEALTH FUND

Administered by
AULTCARE