AULTCARE

Other Coverage Information Form

Group#: _____

Enrollee Name: _____

Member ID #: _____

❑ Actively Working

❑ Retired: Date of Retirement___/____/____

❑ Disabled-Working ❑ Disabled-Not Working

Have you, your spouse, or any dependents covered under this AultCare plan had any other Medical, Dental, Vision, RX, or Medicare coverage in the past 24 months?

❑ No: The rest of the form does not need to be completed, please sign & date second page & return to AultCare.

❑ Yes: Please complete entire form, sign, date, and return to AultCare.

PART 1 ENROLLEE INFORMATION

Do you have health insurance in which you are the enrollee/policyholder other than this AultCare plan?

❑ No ➡ Previous carrier termination date___/____/____ ❑ Yes ➡ complete below.

Is **OTHER** coverage: ❑ Active plan ❑ Retiree plan ❑ COBRA ❑ Individual Plan ❑ Medicare

Insurance Name:_____ Group#_____ Effective Date: ___/____/____

Current Employer Name: _____

Who is covered under **OTHER** plan?_____

Check coverage(s): ❑ MEDICAL ❑ DENTAL ❑ VISION ❑ PRESCRIPTION ❑ SUPPLEMENTAL

PART 2 SPOUSE INFORMATION-COMPLETE IF MARRIED

Spouse's name _____Date of Birth ____/____/____ Date of Marriage ____/____/____

Is spouse employed? ❑ No ❑Yes ➡ Employer_____

Does spouse have other coverage?

❑ **No**➡ ❑Part time ❑ Benefits not offered ❑Unemployed ❑Self employed ❑Cost

❑Waiting period Eligible for coverage ____/____/_____ ❑ Prior coverage terminated:date ___/____/_____

❑**Yes** ➡ Is **OTHER** coverage: ❑ Active plan ❑ Retiree plan ❑ COBRA ❑ Individual Plan ❑ Medicare

Policyholder's Name_____ ID#_____ Group # _____

Insurance Name _____ Effective Date: ____/____/____

Who is covered under spouse's plan? _____

Check coverage(s): ❑ MEDICAL ❑ DENTAL ❑ VISION ❑ PRESCRIPTION ❑ SUPPLEMENTAL

PART 3 CHILDREN INFORMATION-if additional space is needed, complete on the back of form.

Children's first and last names	Relationship	
a.	❑Natural child of enrollee & spouse ❑Natural child of spouse➡**Part 4**	❑Natural child of enrollee➡**Part 4** ❑Other_____➡**Part 4**
b.	❑Natural child of enrollee & spouse ❑Natural child of spouse➡**Part 4**	❑Natural child of enrollee➡**Part 4** ❑Other_____➡**Part 4**
c.	❑Natural child of enrollee & spouse ❑Natural child of spouse➡**Part 4**	❑Natural child of enrollee➡**Part 4** ❑Other_____➡**Part 4**
d.	❑Natural child of enrollee & spouse ❑Natural child of spouse➡**Part 4**	❑Natural child of enrollee➡**Part 4** ❑Other_____➡**Part 4**

** **For any children age 18 or older who have insurance coverage other than through a natural/step parent, please complete part 4A.** **

Group#: _____

Enrollee Name: _____

Member ID #: _____

PART 4 DIVORCED, LEGALLY SEPARATED, SINGLE PARENT OR OTHER

Please complete all information in this section for each child covered under your plan who have a different biological parent other than the enrollee & spouse listed on the first page. If not previously provided, court documentation and/or divorce decrees must be submitted to AultCare in order to accurately update your records

Child 's name_____

Is their address the same as the enrollee? ❑Yes ❑No ➡ provide address _____

If 17 or older, please provide date of graduation from high school _____

Name of other biological/adoptive parent _____Parent's Date of Birth ____/____/____

Other Parent's address _____

Does child(ren) have insurance coverage other than this AultCare plan? ❑ Yes ❑No

Same as spouse's coverage? ❑Yes ❑No ➡complete below

Policyholder's Name_____ Relationship to child_____

Insurance Name _____ Effective Date: ____/____/____ Term date: ____/____/____

Check coverage(s): ❑ MEDICAL ❑ DENTAL ❑VISION ❑PRESCRIPTION ❑ SUPPLEMENTAL

PART 4A CHILDREN WITH INSURANCE COVERAGE OTHER THAN A PARENT'S PLAN

Child 's name_____

Is insurance coverage <u>available</u> through adult child's employer? ❑ Yes ❑ No

Policyholder's Name_____ Relationship to child_____

Insurance Name _____ Effective Date: ____/____/____ Term date: ____/____/____

Check coverage(s): ❑ MEDICAL ❑ DENTAL ❑VISION ❑PRESCRIPTION ❑ SUPPLEMENTAL

PART 5 MEDICARE INFORMATION-PLEASE COMPLETE FOR ALL MEDICARE RECIPIENTS

Name_____

Part A Effective Date ____/____/____

Part B Effective Date ____/____/____

Part D Effective Date ____/____/____

Reason for Medicare coverage:

❑ Age 65 or older ❑ Disabled

❑ End Stage Renal Disease (ESRD)

Date dialysis treatment began ____/____/____

Dialysis started in a: ❑Facility ❑Self/Home dialysis

Date of kidney transplant ____/____/____

Name_____

Part A Effective Date ____/____/____

Part B Effective Date ____/____/____

Part D Effective Date ____/____/____

Reason for Medicare coverage:

❑ Age 65 or older ❑ Disabled

❑ End Stage Renal Disease (ESRD)

Date dialysis treatment began ____/____/____

Dialysis started in a: ❑Facility ❑Self/Home dialysis

Date of kidney transplant ____/____/____

Insurance Fraud Warning: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files any claim containing false or deceptive statements is guilty of insurance fraud."

Enrollee's signature_____ Date_____

Enrollee's phone number_____ Email_____

AULTCARE
ATTN: COB
PO BOX 6910
CANTON OH 44706
FAX 330-363-7746

Note: If any changes occur during the year, please notify the Service Center at 330-363-6360 or 1-800-344-8858.