AULTCARE
www.aultcare.com

MEMBERSHIP REPORT

MAIL TO: AultCare Member Services
PO Box 6910
Canton, OH 44706
FAX: 330-363-7746
SERVICE: 330-363-6360 OR 1-800-344-8858
EMAIL: aultcareeligibility@aultcare.com

TODAY'S DATE: _____
COMPANY: _____
GROUP NUMBER: _____
COMPLETED BY: _____

EFFECTIVE DATE OF TRANSACTION	EMPLOYEE NAME LAST, FIRST, M.	ID NUMBER	TRANS. CODE	COVERAGE TYPE	COMMENTS

Please indicate all changes/updates on this report. Do not make changes on the monthly premium statement. Utilize transaction codes for each change. Include enrollment form where indicated and provide within 31 days of event. ***Signed enrollment forms must include spouse's signature when applicable.**

TRANSACTION CODES

Addition to Enrollment:

1. Addition (Include Enrollment Form) If enrollment is due to SCHIP loss of coverage, please indicate this in the Comments section.

1a. Special Election Period/Measurement Period Qualifying Event (Include Enrollment Form)

Change to Enrollment:

2. Change – Single to Family (Include Enrollment Form)
3. Change – Family to Single (Include Enrollment Form)
4. Change – Name/Address (Specify in Comments section, if name change & include Enrollment Form)
5. Change – Addition of Dependent (Specify in Comments section, include Enrollment Form)
6. Change – Deletion of a Dependent (Specify in Comments, include Enrollment Form with waiver section signed & Divorce Decree if applicable.)
7. Change – Other (Specify in Comments)

Cancellation of Coverage:

8. Cancellation – Left Employment/Termination (Include in Comments section Termination Date & if Voluntary, Involuntary or due to Gross Misconduct)
9. Cancellation – Deceased (Specify Date of Death in Comments section)
10. Cancellation – Layoff (Include in Comments section the Date of Layoff & if Voluntary or Involuntary)
11. Cancellation - Waiving (Specify in Comments if waiving coverage, include Enrollment Form with waiver section signed.)
12. Cancellation – Reduction in hours: no longer meets minimum eligibility requirements

Continuation of Coverage:

13. COBRA Coverage Elected (Include Expiration Date, Copy of signed election form & proof of first payment)
14. State Continuation of Coverage (For companies under 20 – please indicate expiration date of State Continuation of Coverage in the Comments section)

Other:

15. Other (Include detailed explanation)

Form 1338 (93246) R: 6/15, 4/15, 11/11, 9/11, 6/10, 3/09

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Directions on How to Complete the Monthly Membership Report (MMR)

The MMR (Monthly Membership Report) is a tool for the client to transmit enrollment information to AultCare. Listed below are instructions to assist the client when completing the form.

Addition to Enrollment

- #1 - Use transaction code #1 when adding a new enrollment.
- Provide enrollment form.
- If enrollment is due to the dependent losing their coverage with SCHIP (State Children's Health Insurance Plan), please indicate this in the comments section of the MMR. Due to HR2, the dependent has a special enrollment period of 60 days.

- #1a - Use transaction code #1a to indicate a special election period or a measurement period qualifying event.
- Provide enrollment form.

Change to Enrollment

- #2 – use when there is a change to enrollment from single coverage to family coverage.
- Provide enrollment form.

- #3 – use when there is a change to enrollment from family coverage to single coverage.
- Provide enrollment form.

- #4 – use when there is a name or address change.
- If name change, provide new name in the comments section and provide enrollment form.
- If address change, provide new address in the comments section.

- #5 – use when adding a dependent to an existing plan.
- Specify dependents name in comments section.
- Provide enrollment form.

- #6 – use when deleting a dependent.
- Specify dependents name in comments section.
- Provide enrollment form with waiver section signed.
- Provide divorce decree, if applicable.

- #7 – use when the above change reasons do not apply (ex. change in location)
- Specify change in the comments section.
- Provide appropriate paperwork, if necessary.

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  TTY LINE: 330-363-2393 / 1-866-633-4752 for the hearing impaired
- WEBSITE: www.aultcare.com

Cancellation of Coverage

- #8 – use when an employee left employment or terminates.
- Include date of termination in comments section.
- Provide in the comments section whether termination was voluntary or involuntary.
- Provide in comments section whether termination was due to gross misconduct.

- #9 – use when there is a cancellation of coverage due to a death.
- Specify date of death and member's name in the comments section.

- #10 – use when there is a cancellation due to a layoff.
- Provide in comments section the date of the layoff and the last date worked.
- Provide in the comments section whether layoff was voluntary or involuntary.

- #11 – use when there is a cancellation because the member is waiving coverage.
- Provide enrollment form with waiver section signed.
- Specify in the comments section that member is waiving coverage.

- #12 – use when there is a cancellation because the member had a reduction in hours and is no longer meeting the minimum eligibility requirements.

Continuation of Coverage

- #13 – use when member elected COBRA coverage.
- Provide expiration date of COBRA coverage in the comments section.
- Provide copy of COBRA election form and verification of first payment.

- #14 – use when member elected State Continuation Coverage.
- State Continuation Coverage is an extension of the plan for 12-months for companies under 20 employees.
- Please indicate State Continuation Coverage expiration date in the comments section.

Other

- #15 – use when none of the above transaction codes apply. Please provide a detailed explanation.

Revised 6/15, 4/15, 11/11

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