

Group # _____	<input type="checkbox"/> Actively Working
Enrollee Name _____	<input type="checkbox"/> Retired Date of Retirement _____
Member ID # _____	<input type="checkbox"/> Disabled-Working <input type="checkbox"/> 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 and date the second page and 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 for other than this AultCare plan?	
	<input type="checkbox"/> No: Previous Carrier Termination Date _____ <input type="checkbox"/> Yes: Complete below	
	OTHER Coverage: <input type="checkbox"/> Active plan <input type="checkbox"/> Retiree plan <input type="checkbox"/> COBRA <input type="checkbox"/> Individual plan <input type="checkbox"/> Medicare	
	Insurance Name	Group # _____ Effective Date _____
	Current Employer Name _____	
	Who is covered under OTHER plan? _____	
Check coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Supplemental/Medicaid		

PART 2 SPOUSE INFORMATION (complete if married)	Spouse's Name	Date of Birth _____	Date of Marriage _____
	Is spouse employed? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, Name of Employer _____	
	Does spouse have other coverage?		
	<input type="checkbox"/> No → <input type="checkbox"/> Part-time <input type="checkbox"/> Benefits not offered <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Cost <input type="checkbox"/> Waiting period		
	<input type="checkbox"/> Eligible for coverage date _____ <input type="checkbox"/> Date prior coverage terminated _____		
	<input type="checkbox"/> Yes → OTHER coverage: <input type="checkbox"/> Active plan <input type="checkbox"/> Retiree plan <input type="checkbox"/> COBRA <input type="checkbox"/> Individual plan <input type="checkbox"/> Medicare		
	Policyholder's Name	ID # _____	Group # _____
Insurance Name	Effective Date _____		
Who is covered under spouse's plan? _____			
Check coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Supplemental/Medicaid			

PART 3 CHILDREN INFORMATION	Children's First and Last Names	Relationship	
		<input type="checkbox"/> Natural child of enrollee & spouse	<input type="checkbox"/> Natural child of enrollee → Part 4
		<input type="checkbox"/> Natural child of spouse → Part 4	<input type="checkbox"/> Other _____ → Part 4
		<input type="checkbox"/> Natural child of enrollee & spouse	<input type="checkbox"/> Natural child of enrollee → Part 4
		<input type="checkbox"/> Natural child of spouse → Part 4	<input type="checkbox"/> Other _____ → Part 4
	<input type="checkbox"/> Natural child of enrollee & spouse	<input type="checkbox"/> Natural child of enrollee → Part 4	
	<input type="checkbox"/> Natural child of spouse → Part 4	<input type="checkbox"/> Other _____ → Part 4	
	<input type="checkbox"/> Natural child of enrollee & spouse	<input type="checkbox"/> Natural child of enrollee → Part 4	
	<input type="checkbox"/> Natural child of spouse → Part 4	<input type="checkbox"/> Other _____ → Part 4	

If additional space is needed, please use page 3.

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

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 and 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Same as spouse's coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please complete the information below.		
	Policyholder's Name	Relationship to Child	
	Insurance Name	Effective Date	Term Date
	Check coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Supplemental/Medicaid		

PART 4 A CHILDREN WITH INSURANCE COVERAGE OTHER THAN A PARENT'S PLAN	Child's Name		
	Is insurance coverage available through adult child's employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Policyholder's Name	Relationship to Child	
	Insurance Name	Effective Date	Term Date
	Check coverage(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Supplemental/Medicaid		

PART 5 MEDICARE INFORMATION (Please complete for all Medicare recipients)	Name _____	Name _____
	Part A Effective Date _____	Part A Effective Date _____
	Part B Effective Date _____	Part B Effective Date _____
	Part D Effective Date _____	Part D Effective Date _____
	Reason for Medicare coverage: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease (ESRD)	Reason for Medicare coverage: <input type="checkbox"/> Age 65 or older <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease (ESRD)
	Date dialysis treatment began _____	Date dialysis treatment began _____
	Dialysis started at <input type="checkbox"/> Facility <input type="checkbox"/> Self/home dialysis	Dialysis started at <input type="checkbox"/> Facility <input type="checkbox"/> Self/home dialysis
	Date of kidney transplant _____	Date of kidney transplant _____

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.

Enrollee's Signature _____ Date _____

Enrollee's Phone Number _____ Email _____

Please mail, email, or fax this form to: AultCare Attn: COB, PO Box 6910 Canton, OH 44706 | email: aultcareeligibility@aultcare.com | or 330-363-7746 | Attn: COB Note: If any changes occur during the year, please notify AultCare at 330-363-6360 | 1-800-344-8858 | TTY: 711

Please use this sheet for additional space for Other Coverage Information Form.

Group # _____ Enrollee Name _____ Member ID # _____

