DEPENDENT VERIFICATION FORM

Employee Name:	ID Number:
Group Name:	Group Number:
Dependent's Name:	Relationship to Employee:

AultCare verifies dependent information annually to insure that claims are being processed appropriately. Please complete the below form providing information on your dependent's status. Incomplete forms will be returned to the member.

Dependent Information:

1. He/she is _____ years of age and is a full-time student; enrolled for the number of hours specified for full-time status by the institution attended.

   - Name of school _____City _____State_____
   - Number of credit hours: Fall _____ Spring _____
   - Dates that dependent will be enrolled for the 2021 - 2022 school year:
     From_____To _____
     (mo/day/yr) (mo/day/yr)
   - Anticipated graduation date ___/__/___
   - If graduating from High School, will your dependent be attending college in the Fall?
     Yes_____ No_____

2. Is he/she incapable of self-support due to a disabling illness or injury which occurred prior to reaching age 19?
   Yes_____ No_____ (*if yes, another form will be mailed to you*)

I understand that it is my responsibility to notify my benefits office and/or AultCare within 30 days if my dependent's full-time status changes or my dependent does not meet any of my plan's guidelines. I also understand that if I do not notify my benefits office immediately, I may jeopardize my dependent's eligibility to continue coverage at his/her own expense and that the rule against falsification applies. I certify the above is complete and that I am claiming benefits only for charges incurred by eligible dependents.

_____ _____

Signature of Employee Date

Please return completed form in the enclosed self-addressed envelope within 30 days; or you may fax your form to 330-363-7746 Attn: FTS. 08/2018

- P.O. Box 6910 | Canton, OH 44706
- PHONE: 330-363-6360 | TOLL FREE: 1-800-344-8858
  TTY LINE: 711
- WEBSITE: www.aultcare.com