AULTCARE

OTHER COVERAGE INFORMATION FORM

Group # ____________________ ☐ Actively Working

Enrollee Name ____________________ ☐ Retired Date of Retirement ____________

Member ID # ____________________ ☐ 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 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?

☐ No: Previous Carrier Termination Date ☐ Yes: Complete below

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/Medicaid

PART 2 SPOUSE INFORMATION (complete if married)

Spouse's Name	Date of Birth	Date of Marriage

Is spouse employed? ☐ No ☐ Yes | If Yes, Name of Employer

Does spouse have other coverage?

☐ No → ☐ Part-time ☐ Benefits not offered ☐ Unemployed ☐ Self-employed ☐ Cost ☐ Waiting period
☐ Eligible for coverage date ____________ ☐ Date prior coverage terminated ____________

☐ Yes → **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/Medicaid

PART 3 CHILDREN INFORMATION

Children's First and Last Names	Relationship
	☐ Natural child of enrollee & spouse ☐ Natural child of enrollee → **Part 4** ☐ Natural child of spouse → **Part 4** ☐ Other__________ → **Part 4**
	☐ Natural child of enrollee & spouse ☐ Natural child of enrollee → **Part 4** ☐ Natural child of spouse → **Part 4** ☐ Other__________ → **Part 4**
	☐ Natural child of enrollee & spouse ☐ Natural child of enrollee → **Part 4** ☐ Natural child of spouse → **Part 4** ☐ Other__________ → **Part 4**
	☐ Natural child of enrollee & spouse ☐ Natural child of enrollee → **Part 4** ☐ Natural child of spouse → **Part 4** ☐ 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.

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 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

Same as spouse's coverage? ☐ Yes ☐ No If no, please complete the information below.

Policyholder's Name	Relationship to Child	
Insurance Name	Effective Date	Term Date

Check coverage(s): ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ 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? ☐ Yes ☐ No

Policyholder's Name	Relationship to Child	
Insurance Name	Effective Date	Term Date

Check coverage(s): ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Supplemental/Medicaid

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 at ☐ 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 at ☐ Facility ☐ Self/home dialysis

Date of kidney transplant _____

Insurance Fraud Warning: Any person who, with intent to defraud or knowing that they are 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 _____

Please mail, email, or fax this form to: AultCare Attn: Timken Service Unit COB, PO Box 6910 Canton, OH 44706 | aultcareeligibility@aultcare.com | or 330-580-5501 Attn: Timken Service Unit COB

Note: If any changes occur during the year, please notify AultCare at 330-363-6282 | 1-800-505-2858 | TTY: 711.

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

Group # _____ Enrollee Name _____ Member ID # _____