

Group #: \_\_\_\_\_  Actively Working  
 Enrollee Name: \_\_\_\_\_  Retired date of retirement \_\_\_/\_\_\_/\_\_\_  
 ID # \_\_\_\_\_  Disabled-Working  Disabled-Not Working

\*\*\*\*\*Please complete each part that applies to you and your dependents. Please print.\*\*\*\*\*

**Part 1 ENROLLEE INFORMATION - All enrollees must complete.**

Do you have coverage **OTHER** than this group # \_\_\_\_\_ where you are the policyholder?  
 No ➔ Previous carrier termination date \_\_\_/\_\_\_/\_\_\_ (if within the last 24 months) ➔ **Part 2.**  
 Yes ➔ Is **OTHER** coverage:  Active plan  Retiree plan  Medicare ➔ **Part 3.**  
 Insurance Name: \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date: \_\_\_/\_\_\_/\_\_\_  
 Current Company Name: \_\_\_\_\_ # of employees  Less than 20  20-99  100+  
 Who is covered under **OTHER** plan? \_\_\_\_\_  
 Check coverage(s):  MEDICAL  DENTAL  VISION  PRESCRIPTION  SUPPLEMENTAL  HRA/HSA  FLEXIBLE SPENDING

**Part 2 SPOUSE INFORMATION - Complete, if married.**

Spouse's name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Date of Marriage \_\_\_/\_\_\_/\_\_\_  
 Is spouse employed?  No  Yes ➔ Employer \_\_\_\_\_ # of employees:  Less than 20  20-99  100+  
 Does spouse have other coverage?  No ➔ **Part 2b.**  Yes ➔ **Part 2a.**

**Part 2a SPOUSE WITH OTHER COVERAGE**

Is spouse's coverage:  Active plan  Retiree plan  Medicare ➔ **Part 3.**  
 Policyholder's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Insurance Name \_\_\_\_\_ Effective Date: \_\_\_/\_\_\_/\_\_\_  
 Who is covered under spouse's plan? \_\_\_\_\_  
 Check coverage(s):  MEDICAL  DENTAL  VISION  PRESCRIPTION  SUPPLEMENTAL  HRA/HSA  FLEXIBLE SPENDING

**Part 2b SPOUSE WITHOUT OTHER COVERAGE - Check reason**

Prior coverage terminated: Termination date \_\_\_/\_\_\_/\_\_\_  Benefits not offered  Unemployed  Self employed  
 Part time employee (not eligible for benefits)  Waiting period Eligible for coverage \_\_\_/\_\_\_/\_\_\_  
 Waived as of \_\_\_/\_\_\_/\_\_\_ Reason for waiving coverage: \_\_\_\_\_  
 Other, please explain \_\_\_\_\_

**Part 3 MEDICARE COVERAGE - Complete, if you or your dependents have MEDICARE coverage.**

Name of person covered by Medicare: _____	Name of person covered by Medicare: _____
Medicare # _____	Medicare # _____
Part A Effective Date ___/___/___	Part A Effective Date ___/___/___
Part B Effective Date ___/___/___	Part B Effective Date ___/___/___
Part D Effective Date ___/___/___ Term Date ___/___/___	Part D Effective Date ___/___/___ Term Date ___/___/___
Part D Carrier Name _____	Part D Carrier Name _____
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 of kidney transplant ___/___/___	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 of kidney transplant ___/___/___

**If you don't have children listed on this policy, skip Parts 4 & 5 and sign and date on Page 2.**

Group #: \_\_\_\_\_  
 Enrollee Name: \_\_\_\_\_  
 ID # \_\_\_\_\_

**Part 4 CHILDREN INFORMATION - Complete for all children covered under this group -# \_\_\_\_\_**

Child's first and last name	Other Coverage? If no, provide termination date only if within 24 months	Insurance Name	Effective Date	Circle Coverage (see key below*)	Policyholder's first and last name & Relationship to Child
	<input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes →		__/__/__	M D V R S H F	
	<input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes →		__/__/__	M D V R S H F	
	<input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes →		__/__/__	M D V R S H F	
	<input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes →		__/__/__	M D V R S H F	
	<input type="checkbox"/> No → Term date __/__/__ <input type="checkbox"/> Yes →		__/__/__	M D V R S H F	

\*Coverage Type key: M=Medical D=Dental V=Vision R=Prescription S=Supplemental H=HRA/HSA F=Flexible Spending

**Part 5 DIVORCED, LEGALLY SEPARATED or SINGLE PARENT - Complete, if you have child(ren) covered under this group# \_\_\_\_\_. Complete this part even if some of the information duplicates information provided in Part 4.**

**Note: If you have a divorce decree/court order which indicates who is responsible to provide healthcare coverage for your child (ren), please attach a copy.** The required sections are:

- 1.) the first section, which lists the names of who the divorce decree/court order pertains to,
- 2.) the section which lists the child(ren) ,
- 3.) the section which includes the shared parenting/custody arrangements,
- 4.) the healthcare coverage section, and
- 5.) the last page with signature and stamped court file date.

**If you have previously provided us with a copy of your divorce decree/court order AND there are no changes, you do not need to submit another copy.**

Check the correct statement:

- I acknowledge that there are no changes to my divorce decree/court order that I previously submitted to AultCare.
- I have attached my divorce decree/court order with changes to this form.
- I have attached my divorce decree/court order for the first time to AultCare.

**If there is more than one child and there is a different biological/adoptive parent, please check this box  and provide all of the following information on the back of this page.**

Child (ren)'s first and last names: \_\_\_\_\_

Child(ren)'s address \_\_\_\_\_

Name of other biological/adoptive parent \_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_

Address \_\_\_\_\_

Insurance Name \_\_\_\_\_ Effective Date \_\_/\_\_/\_\_ Termination Date \_\_/\_\_/\_\_

If the divorce decree/court order states the other parent is responsible, but the other parent does not have coverage for your child(ren), please check reason:

- Other parent is unemployed and unable to provide coverage for child (ren).
- Other parent's employer does not offer coverage.
- No knowledge of where other parent resides.
- Never married, no other coverage available.
- Other. Please explain on the back of this page.

**SIGNATURE (Required)**

I understand failure to provide adequate, complete and truthful information may result in the denial of claim payment(s). I hereby certify that the statements contained herein are true to the best of my knowledge.

Enrollee's Signature \_\_\_\_\_

Date \_\_\_\_\_

Enrollee's Phone Number \_\_\_\_\_

Enrollee's e-mail address \_\_\_\_\_

AULTCARE  
 ATTN: COB  
 P.O. BOX 6910  
 CANTON, OH 44706  
 330-363-6360 or 1-800-344-8858

**Note: If any changes occur during the year, please notify the Service Center.**