



## DEPENDENT VERIFICATION FORM

EMPLOYEE'S NAME: _____	ID NUMBER: _____
GROUP NAME: _____	GROUP NUMBER: _____
DEPENDENT NAME: _____	RELATIONSHIP TO EMPLOYEE: _____

AultCare verifies dependent information annually to insure that claims are being processed according to your plan's guidelines. **Please complete either Section A or B entirely depending on your dependent's status. Incomplete forms will be returned to the member.** You may visit our website to update this information online.

### **A. Eligible Dependent:**

- I certify that \_\_\_\_\_ is unmarried and dependent upon me for principal support, and that he/she follows the definition of a dependent per my plan guidelines.
- He/she is \_\_\_\_\_ year of age and is a full-time student; enrolled for the number of hours specified for full-time status by the institution attended.  
 Number of credit hours: Spring \_\_\_\_\_ Fall \_\_\_\_\_  
 Date that dependent will be enrolled for the 20\_\_\_\_ - 20\_\_\_\_ school year: FROM \_\_\_\_\_ TO \_\_\_\_\_  
(mo./day/yr.) (mo./day/yr.)  
 Name of school \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Anticipated graduation date \_\_\_\_ / \_\_\_\_ /20\_\_\_\_ If graduating from High School, will your dependent be attending college in the Fall? Yes \_\_\_\_\_ No \_\_\_\_\_
- Is he/she employed? YES \_\_\_\_\_ NO \_\_\_\_\_ Average number of hours worked per week: \_\_\_\_\_
- 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)

### **B. Ineligible dependent due to:**

- \_\_\_\_\_ Attaining age 19 on (date): \_\_\_\_\_
- \_\_\_\_\_ Terminating or completing full-time schooling. Date schooling was completed: \_\_\_\_\_
- \_\_\_\_\_ Marriage. Date of marriage: \_\_\_\_\_
- \_\_\_\_\_ Attaining maximum age to be covered as a dependent on (date): \_\_\_\_\_

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 Enrollee

\_\_\_\_\_  
Date

**Please return completed form in the enclosed self-addressed envelope within 30 days regardless of their status. Failure to do so may result in termination. You may choose to fax your form to: 330-363-7746 Attn: FTS**

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- P.O. Box 6910 / Canton, OH 44706-0910
- PHONE: 330.363.6360 / TOLL FREE: 1.800.344.8858 / TTY LINE: 330.363.2393 / 1.866.633.4752
- WEBSITE: www.aultcare.com

