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 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 # _____