AULTCARE

DEPENDENT VERIFICATION FORM

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

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

DEPENDENT INFORMATION

☐ The dependent 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 dependent will be enrolled for the school year: From _____ To _____
(MM/DD/YYYY) (MM/DD/YYYY)

Anticipated Graduation Date _____

If graduating from high school, will your dependent be attending college in the fall? ☐Yes ☐No

☐ Is the dependent 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 it is my responsibility to notify my benefit's 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 if I do not notify my benefit's office immediately, I may jeopardize my dependent's eligibility to continue coverage at his/her own expense and the rule against falsification applies. I certify the above is complete and I am claiming benefits only for charges incurred by eligible dependents.

Signature of Employee _____ Date _____

Please return the completed form in the self-addressed envelope within 30 days. You may also fax your form to 330-363-7746 Attn: FTS.