AULTCARE

Enrollment Application/Change Form

with Medical Questions

AULTCARE USE ONLY	
Date Completed	Completed By
Card Sent	

EMPLOYER USE ONLY		
Employer Name		Employer Group Numbers
Employee Location/ Job Classification	Leased Network ☐Yes ☐No	AultCare Effective Date

EMPLOYEE COVERAGE ELECTION

A) NEW POLICY APPLICATION ☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Waiving Coverage

☐You Only ☐You & Your Spouse ☐You & Your Child(ren) ☐You, Your Spouse & Your Child(ren)

☐Qualifying Event – Explain: _____

Date of Qualifying Event _____

(Qualified enrollment must be made within 31 days of event)

B) EMPLOYEE INFORMATION	Last Name	First Name	Middle Initial	Suffix
Sex ☐Male ☐Female	Date of Birth	Social Security Number		
Home Address (Number & Street)	County	City	State	Zip Code
Preferred Phone Number	Email Address			
Marital Status ☐ Married – Date of Marriage	☐Single ☐Widowed ☐Divorced ☐Separated			
Employment Status ☐Full Time ☐Part-Time ☐Retired ☐COBRA	Currently on Hire Date	Hours Worked Per Week	Are you currently actively at work? ☐Yes ☐No If not, why? _____	
Coverage Type(s) Requested: Check All that Apply ☐Medical ☐Dental ☐Rx ☐Vision ☐STD ☐Life ☐Flex ☐HSA ☐HRA	Plan Requested: Plan Name _____			

ADDITIONAL COVERAGE FOR DEPENDENTS

A(dd), C(hange), D(elete)	Relationship to Enrollee	First Name	M.I.	Last Name (If different from employee)	Social Security Number	Benefits Selected (M,D,V,R)	Sex (M or F)	Date of Birth	Other Insurance Coverage? (Y/N)

M - Medical D - Dental V - Vision R - Prescription

IMPORTANT INFORMATION

OTHER COVERAGE INFORMATION

Upon your effective date with this plan, will you or any of your family members have other health insurance? ☐ YES ☐ NO

If yes, what is the name of the other insurance company?

If yes, what type(s) of other health insurance will you have? Check all that apply ☐ Medical ☐ Dental ☐ Rx ☐ Vision

MEDICARE INFORMATION

Do you or your spouse or any enrolled dependents have Medicare coverage? ☐ YES ☐ NO If yes, please provide information below.

Medicare Enrollee Name	Medicare ID Number	Hospital Effective Date (Part A)	Medical Effective Date (Part B)

Do you have Medicare Part D coverage? ☐ YES ☐ NO

If yes, what is the effective date of your coverage?

OTHER INFORMATION

Do you, or any of your dependents, have any cultural or linguistic needs? ☐ YES ☐ NO

If yes, what are they?

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Choose not to answer

Race: ☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Choose not to answer

Language: ☐ English ☐ Spanish ☐ Other _____

MEDICAL INFORMATION (A)

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR YOU, YOUR SPOUSE AND ALL CHILDREN, IF ENROLLING.

☐ Yes ☐ No 1. Are you, your spouse or any of your children the parent of a child that is expected to be born in the next nine months?
If yes, who? _____ Expected due date: _____

☐ Yes ☐ No 2. Has anyone ever had high blood pressure, heart disease, cancer, diabetes, mental or nervous disorder, or been treated for alcohol or chemical dependency?

☐ Yes ☐ No 3. Has anyone ever been treated for AIDS or an AIDS-related condition (ARC)?

☐ Yes ☐ No 4. Has anyone ever been prescribed medication in the past three years?

☐ Yes ☐ No 5. Has anyone had inpatient or outpatient surgery during the past 10 years?

☐ Yes ☐ No 6. During the past three years, has anyone sought medical treatment or been advised by a medical authority to seek treatment for any condition not indicated by your answers to the preceding five questions?

If you desire confidentiality, seal this application in an envelope and give it to your employer.

If you answered yes to any of the medical questions 2-6 above, please provide an explanation in Medical Information (B).

If all answers to the medical questions above are no, simply read and sign where applicable on next page.

MEDICAL INFORMATION (B)

Please explain YES answers to any question in Medical Information (A). Give complete details. If you need additional space, please attach a separate page.

Question # / Condition	Name of Individual	Physician's Name and Address	Treatment Dates (from/to)	Diagnosis, Treatment, Prognosis, Medication, Dosage and Reason (be specific)

RELEASE OF INFORMATION/PLEASE READ CAREFULLY

I am applying for group health coverage through AultCare Insurance Company and its related entities ("AultCare"). I acknowledge the coverage for which I am applying is subject to eligibility requirements and the terms of the policy. I acknowledge that I have read and understood all of the information contained within this document. Additionally, I acknowledge that all information that I have entered in this application, to the best of my knowledge, is complete, true, and accurate. I understand that any attempt to mislead or defraud AultCare is considered insurance fraud.

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.

All Employees

I have read all of the statements contained in this application and declare that by signing this application the information I have provided is true and complete to the best of my knowledge. Electronic Signature Disclaimer: Please be advised that AultCare will not deny the enforceability or effect of an electronic signature solely because it is in an electronic format. Any valid signature provided in this section shall have the same legal effect and enforceability as a manually executed signature. I authorize deduction from my wages, as necessary, for any required premium for the coverage for which I have applied.

Signature _____ Date _____

Employees Waiving Coverage

I have read all of the statements contained in this application and declare by signing that the information I have provided is true and complete to the best of my knowledge. I understand that I am eligible to apply for coverage through my employer. And I acknowledge that, subject to the terms and conditions of the policy, by waiving coverage at this time, I may not be able to enroll myself or my family again until the next annual enrollment period or a special enrollment period. I hereby decline coverage for (check all that apply): ☐ Myself ☐ Spouse ☐ Child(ren)

Reason for waiver of coverage: _____

Signature _____ Spouse Signature _____ Date _____

Per the 2015 FTC TCPA, AultCare or a vendor of AultCare, may contact you for demographic, satisfaction, and/or medical care management information in accordance with its obligation under Federal Law.

Please submit this form to AultCare:

Email: aultcaresales@aultcare.com | Contact AultCare Sales with questions: 330-363-1137.

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