Group Employee Application

Group# ____________________

Employee Name: ____________________

Company Name: ____________________

☐ New Company

☐ New Employee

☐ Change Group# ____________________

Effective Date ______________

AULTCARE

AultCare has become the area's leading local health plan by providing exceptional member services since 1985. AultCare's health plans provide your employees with comprehensive benefits, superior customer service and simplified claims filing. The AultCare Preferred Provider Organization (PPO) offers a network of over 2,000 physicians, specialists and hospitals. You may choose any physician you want, however the plans pay greater benefits to those who select providers in the AultCare PPO network. You can count on AultCare's commitment of delivering the highest quality healthcare at the lowest possible cost.

Insured health plans are underwritten and issued by McKinley Life Insurance Company to the Master Group Policyholder. If you have any questions, please call the AultCare Service Center at 330-363-6360, or visit us at www.aultcare.com.

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.*

M1040

Large Group

AULTCARE USE ONLY

EM	EAM	EDM	ENF	COBM	Date Completed	Completed By	Card Sent

EMPLOYER USE ONLY

Group Name	Group Number	Location Code

Coverage Type(s) Requested: (Check all that apply)
☐ Medical ☐ Dental ☐ RX ☐ Vision

AultCare Effective Date

(1) COVERAGE INFORMATION

Please Check Plan Type:
☐ PPO ☐ HMO ☐ POS (Point of Service) ☐ Other ______

A) NEW POLICY APPLICATION

1. Reason for enrollment
☐ New Group ☐ New Hire
☐ Change in family/employment status
(Complete all sections on application)
Explain: ______

2. Who do you want covered?
☐ You Only ☐ You & Your Spouse ☐ You & Your Child(ren)
☐ You, Your Spouse & Your Child(ren)
☐ I'm ineligible for coverage ☐ I'm waiving coverage

B) CHANGE TO AN EXISTING POLICY

1. Date of Change: ______ 2. Requested Effective Date: ______
☐ Add a Child (Complete all sections on application)
Date of birth/adoption: ______
☐ Add a Spouse (Complete all sections on application)
Date of marriage: ______
☐ Change in Name or Address (Complete sections 2 and sign section 5 as Eligible Employee)
☐ Former name: ______
Deleting a Dependent from Policy (Complete sections 3 and sign section 5 as Eligible Employee)

COBRA SECTION

Covered Under: ☐ Cobra ☐ State Continuation
Qualifying Event: ☐ Termination/Retirement ☐ Divorce ☐ Reduction in Hours
☐ No Longer Eligible ☐ Other Qualifying Event Date ______

(2) EMPLOYEE INFORMATION

Employee Last Name	First Name	Middle	Social Security Number

Home Address (Number & Street)	County	Date of Birth

City	State	Zip Code	Home Phone	Sex: ☐ Male ☐ Female

Marital Status
☐ Single ☐ Married (Date of Marriage) ______ ☐ Widowed ☐ Divorced ☐ Separated

Employment Status
Date of Hire: ______
☐ Full-Time ☐ Part-Time ☐ Retired

Hours Worked: ______

Are you currently actively at work? ☐ YES ☐ NO
If no, why? ______

Do you, or any of your dependents, have any cultural or linguistic needs? ☐ YES ☐ NO
If yes, what are they?

(3) EMPLOYEE/DEPENDENT INFORMATION

A(dd) C(hange) D(elete)	Relationship	First Name	M.I.	Last Name (If different from employee)	Social Security Number	Sex M or F	Date of Birth
	Employee				/ /		/ /
	Spouse				/ /		/ /
	Spouse's Employer				/ /		/ /
	Child*				/ /		/ /
	Child*				/ /		/ /
	Child*				/ /		/ /
	Child*				/ /		/ /
	Child*				/ /		/ /

*Children age 19 or older must be attending an accredited college full-time and eligible to be claimed as a dependent on the Employee's income tax form to be eligible for coverage. Complete the section below for all children age 19 and over.

Child's Name	College or University Name and Address	# of Credit Hours	Claimed on Employee's Income Tax?

Do any of your enrolled children live at a different address? Name: __________________ Address: ____________________

If your spouse or any of your enrolled children are permanently disabled please provide their name(s):______________________________

Have you, your spouse, or any of your children submitted claims to AultCare in the past 12 months?______________________________

If yes, please list employer group name: ____

Upon your effective Date with AultCare, 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? (circle all that apply) Medical Dental RX Vision

(4) MEDICARE INFORMATION

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

Medicare Enrollee Name | Medicare ID#

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 Part D coverage?

NAME: **GROUP NAME:**

(5) SIGNATURES

Sign if Applicable to Your Plan:

I authorize deduction from my wages, as necessary, for any required premium for the coverage for which I have applied.

______________________________ ____________________

Your Signature **Date**

Release of Information. Please Read Carefully.
All information in this application, to the best of my knowledge, is complete, true and accurate. I give my consent for AultCare/MLIC to request from any provider of medical, dental or pharmacy services, any insurance company, organization, or my employer to release medical records, billing records, or any information requested with regard to any claim and/or expense reported regarding my condition or that of my family members to be covered.

I consent to allow AultCare Corporation/MLIC to use and disclose my personal information and the personal health information of my family members to be covered to any other insurance company or health plan, any state or federal agency providing health care benefits, and other persons or organizations that perform professional, business, or insurance functions for AultCare such as independent claims examiners or group plan administrators or reinsurers. I understand that this information may be used for purposes that include but are not limited to: processing my application for enrollment; group risk classification; detecting or preventing fraud; internal and external audits; administration of claims; case management; quality improvement programs, reviews, and audits; public health reporting; peer review; utilization review; coordination of benefits; subrogation; health promotion, disease management and prevention, and any other managed care and prevention program. I authorize AultCare to use and disclose my personal health information and the personal health information of my family members to be covered, including but not limited to information from and concerning: mental health records; substance abuse records; reproductive health; information relating to HIV virus or AIDS; or sexually transmitted or other communicable disease. I give this authorization on behalf of any eligible children and myself if covered by the plan. I am acting as their agent and representative.

Authorizations signed for the purpose of collecting information with this application for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date this application is signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and a photocopy is as valid as the original.

Eligible and Ineligible Employees
I have read all of the statements contained in this application and declare by signing this application the information I have provided is true and complete to the best of my knowledge. Signature of Spouse authorizes release of information described previously on this application.

Your Signature ______________________ Spouse's Signature (Required) ______________________ Date __________

Employees Waiving Coverage for Any Family Member
I have read all of the statements contained in this application and declare by signing this application 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. I hereby decline coverage for (check all that apply): ☐ Myself ☐ Spouse ☐ Child(ren)
Reason for waiver of coverage:____
Signature of Spouse authorizes release of information described previously on this application.

Your Signature ______________________ Spouse's Signature (Required) ______________________ Date __________

ADDITIONAL INFORMATION:

AULTCARE
HEALTH PLANS

2600 Sixth Street S.W. • Canton, Ohio 44710

330-363-6360 • 1-800-344-8858