AULTCARE

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. Michelle's Law notice enclosed.

A. Eligible Dependent:

1. 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.

2. 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_____ (mo./day/yr.) TO _____ (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_____

3. Is he/she employed? YES_____ NO_____ Average number of hours worked per week: _____

4. 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)

5. Is he/she an IRS dependent? YES_____ NO_____

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

- 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

NCQA ACCREDITATION