APPLICANT NAME:

AULTONE

AultOne - Health Plans for individuals and their families.
AultCare has become the area's leading local health plan by providing exceptional member service since 1985. AultCare's health plans provide you with comprehensive benefits, superior customer service and simplified claims filing with a network of over 2,000 providers.

AultCare...Good for you!

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.*

This product is underwritten and issued by McKinley Life Insurance Company (MLIC). Coverage is provided through a Trust Agreement between AultCare Corporation and McKinley Life Insurance Company (MLIC). If you have any questions, please call the AultCare Service Center at 330-363-6360, or visit us at www.aultcare.com or www.AultOneOnline.com.

M1041-2 Rev. 08

REASON FOR APPLICATION

☐ New Individual Plan ☐ Open Enrollment ☐ Additional Coverage

I. AGENT CERTIFICATION

Agent Name (please print)	Agent Tax ID

II. FAMILY MEMBERS TO BE COVERED

Applicant Last Name	First Name	Middle	Social Security Number

Home Address (number & street, cannot mail to a P.O. Box)	County

City	State	Zip	Home Phone	Sex ☐ Female ☐ Male

Mailing Address (if different than home) City, State, Zip, County	Email Address

Are you currently actively employed? ☐ Yes ☐ No	Occupation	Employer Name Address, City, County

Height	Weight	Date of Birth	Marital Status ☐ Single ☐ Married (date of marriage) _____ ☐ Widowed ☐ Divorced ☐ Separated

Do you currently have health insurance coverage? ☐ Yes ☐ No Insurance Co.: _____	Do you currently have Workers' Compensation coverage? ☐ Yes ☐ No

Relationship to the Applicant	Last Name	First Name	M.I.	Social Security #	Sex M/F	Ht.	Wt.	Date of Birth	Does Dependent currently have health insurance coverage?	If yes, what is the name of the other insurance company?
Spouse									☐ Yes ☐ No	
Child									☐ Yes ☐ No	
Child									☐ Yes ☐ No	
Child									☐ Yes ☐ No	
Child									☐ Yes ☐ No	

*Children age 26-27 must be residents of Ohio or attending an accredited college full time, unmarried, not eligible for health benefits through an employer, not eligible for Medicare or Medicaid, and not in the armed forces or any country to be eligible for coverage. Complete the section below for all children age 26-27.

Child's Name	College or University	# Credit Hours/Term	Anticipated Date of Graduation

If any of your eligible children live at a different address from yours, please list them below:

Name of child Address

Do you, your spouse, or any of your eligible children live outside the state of Ohio for longer than 3 months during the calendar year? ☐ Yes ☐ No

If your spouse or any of your eligible children are permanently disabled, please list their names:

Have you, your spouse, or any of your eligible children submitted claims to AultCare in the past 12 months? ☐ Yes ☐ No
If so, list employer Group Name:

III. MEDICAL INFORMATION

Regarding the following list of conditions, have you, your spouse, or any eligible children, within the past 5 years:

- been treated for a medical condition,
- been diagnosed as having a medical condition,
- been recommended for a future surgery,
- had diagnostic testing or medical treatment,
- thought you should seek medical advice for any medical conditions

Each condition listed below must be Checked (✔) YES or NO. Please list question number/condition and explanation in Medical Details Space.

Condition	Yes	No
1. Abnormal Pap Smears	☐	☐
2. Allergies	☐	☐
3. Alzheimer's Disease	☐	☐
4. Aneurysm	☐	☐
5. Anemia	☐	☐
6. Angina/Chest Pain	☐	☐
7. Arthritis	☐	☐
Type: _____		
8. Asthma	☐	☐
9. Ataxia	☐	☐
10. Back Strains	☐	☐
11. Bronchitis-Chronic	☐	☐
12. Bursitis	☐	☐
13. Cancer	☐	☐
Type: _____		
Date Last Treated: _____		
Chemotherapy, radiation, or both (please circle)		
Stage of Cancer: _____		
14. Cardiac Arrest	☐	☐
15. Cardiomyopathy/Enlarged Heart	☐	☐
16. Carotid Artery Disease	☐	☐
17. Carpal Tunnel Syndrome	☐	☐
18. Cataracts	☐	☐
19. Cerebral Palsy	☐	☐
20. Chemical Dependency	☐	☐
21. Cholesterol (High)	☐	☐
22. Chronic Obstructive Pulmonary Disease	☐	☐
23. Crohn's Disease	☐	☐
24. Cirrhosis of the Liver	☐	☐
25. Colitis	☐	☐
26. Congenital Disorders	☐	☐
27. Congestive Heart Failure	☐	☐
28. Coronary Artery Disease	☐	☐
29. Coronary Insufficiency	☐	☐
30. Cystic Fibrosis	☐	☐
31. Cystitis	☐	☐
32. Depression and/or Mental Health Disorder	☐	☐
33. Diabetes	☐	☐
Type 1 or Type 2 (please circle)		
Last A1C Result: _____		
Date: _____		
34. Diverticulitis/Diverticulosis	☐	☐
35. Down's Syndrome	☐	☐
36. Emphysema	☐	☐
37. Endometriosis	☐	☐
38. Epilepsy	☐	☐
39. Fibrocystic Breast Disease	☐	☐
40. Fibromyalgia	☐	☐
41. Gallbladder Disease	☐	☐
42. Gastric Reflux	☐	☐
43. Gout	☐	☐
44. Graves' Disease	☐	☐
45. Guillain-Barre Syndrome	☐	☐
46. Heart Attack	☐	☐
47. Heart Bypass	☐	☐
(Date: _____)		
48. Heart Murmur	☐	☐
49. Heart Stents	☐	☐
50. Hemorrhoids	☐	☐
51. Hemophilia	☐	☐
52. Hepatitis	☐	☐
Type: _____		
53. High Blood Pressure	☐	☐
54. Hydrocephalus	☐	☐
55. Hyperthyroidism	☐	☐
56. Hysterectomy	☐	☐
57. Ileostomy	☐	☐
58. Infertility	☐	☐
59. Kidney Failure	☐	☐
60. Kidney Stones	☐	☐
61. Leukemia	☐	☐
62. Lou Gehrig's Disease	☐	☐
63. Major Organ Transplant	☐	☐
Type: _____		
Date: _____		
64. Meningitis	☐	☐
65. Migraines	☐	☐
66. Multiple Sclerosis	☐	☐
67. Muscular Dystrophy	☐	☐
68. Open Heart Surgery Candidate	☐	☐
69. Otitis Media (ear infections)	☐	☐
70. Ovarian Cyst	☐	☐
71. Pacemaker Implantation	☐	☐
72. Pancreatitis	☐	☐
73. Parkinson's Disease	☐	☐
74. Paralysis	☐	☐
75. Peptic Ulcer	☐	☐
76. Peripheral Vascular Disease	☐	☐
77. Phlebitis	☐	☐
78. Polycystic Kidney Disease	☐	☐
79. Prostate Disorders	☐	☐
80. Renal Failure	☐	☐
81. Respiratory Failure	☐	☐
82. Scleroderma	☐	☐
83. Sleep Apnea	☐	☐
84. Speech and/or Moving Disorder	☐	☐
85. Spina Bifida Cystica	☐	☐
86. Spinal Disorders	☐	☐
87. Stroke (Date: _____)	☐	☐
88. Systemic Lupus	☐	☐
89. Tendonitis	☐	☐
90. Thyroid Disorder	☐	☐
91. TMJ	☐	☐
92. Tonsillitis	☐	☐
93. Transient Ischemic Attacks	☐	☐
94. Tumors	☐	☐
95. Varicose Veins	☐	☐
96. Other Conditions	☐	☐

Medical Details. (If you answered YES to any questions/conditions 1-96, please provide details below) Use additional paper if needed.

Condition #	Name of Individual being treated	Details of Condition	Dates of treatment	Name of medication and dosage (milligrams, pills per day, etc.)	Physician's name and phone #	Diagnosis

IV. ADDITIONAL MEDICAL QUESTIONS

YES	NO	
☐	☐	1. Has anyone listed on this application tested positive for HIV or been diagnosed with AIDS or ARC(AIDS-related complex)?
☐	☐	2. Are you, your spouse or any children listed on this application the parent of a child expected to be born in the next nine months? If yes, Who _____ Expected Due Date _____
☐	☐	3. Has anyone been prescribed medication, shots, injections or oxygen therapy in the past three years? If yes, please list all _____
☐	☐	4. Has anyone had inpatient/outpatient surgery in the past 10 years? If yes, please provide explanation and dates of service. _____
☐	☐	5. Is anyone facing a possible surgery, therapy, prescription or procedure as a result of a prior treatment, biopsy, mammogram, or diagnosis? If yes, please provide explanation. _____
☐	☐	6. Is anyone currently hospitalized, or has anyone been hospitalized in the past 10 years?
☐	☐	7. Has any insurance company refused or restricted any health coverage on any person listed on this application? If yes, please provide explanation. _____
☐	☐	8. Does anyone have a condition covered by workers' compensation? If yes, please provide explanation. _____
☐	☐	9. Has anyone listed on this application ever smoked or used any form of tobacco products? If yes, Who _____ Form _____ Length of Usage _____
☐	☐	10. Has anyone listed on this application abused or had a chemical dependency of alcohol or drugs in the past 5 years?

V. HIPAA ELIGIBILITY

Federally Eligible Individuals

1. Have you had health coverage for at least 18 months without a break in coverage greater than 63 days?
☐ YES; ALL MEMBERS ☐ NO; PLEASE LIST MEMBER(S) _____

2. Was your most recent health coverage under a group health plan, government plan or church plan?
☐ YES; ALL MEMBERS ☐ NO; PLEASE LIST MEMBER(S) _____

3. Are you eligible for coverage under a group health plan, Medicare or Medicaid plan?
☐ NO; ALL MEMBERS ☐ YES; PLEASE LIST MEMBER(S) _____

4. Do you have any other health coverage?
☐ NO; ALL MEMBERS ☐ YES; PLEASE LIST MEMBER(S) _____

5. Was your most recent health coverage terminated because of nonpayment of premiums or fraud?
☐ NO; ALL MEMBERS ☐ YES; PLEASE LIST MEMBER(S) _____

6. If you had been offered the option to continue coverage under COBRA or a state continuation plan did you elect and exhaust the continuation coverage?
☐ YES; ALL MEMBERS ☐ NO; PLEASE LIST MEMBER(S) _____

Non-Federally Eligible Individuals

1. Are you applying for coverage as an employee of an employer, member of an association, or member of any other group?
☐ NO; ALL MEMBERS ☐ YES; PLEASE LIST MEMBER(S) _____

2. Do you have any other health coverage?
☐ NO; ALL MEMBERS ☐ YES; PLEASE LIST MEMBER(S) _____

3. Are you eligible for coverage under any private or public health plan including Medicare or Medicaid?
☐ NO; ALL MEMBERS ☐ YES; PLEASE LIST MEMBER(S) _____

VI. RELEASE OF INFORMATION. PLEASE READ CAREFULLY.

I hereby apply for this coverage through the AultCare Insurance Trust. I further agree to participate in such Trust and agree to be bound to the relevant terms of the Master Group Policy, the Trust Agreement, and my Certificate of Insurance. **All information** in this application, to the best of my knowledge, is complete, true and accurate. I give my consent to AultCare/MLIC or its affiliated companies or authorized designees ("AultCare") to request from any provider of medical, dental or pharmacy services, any insurance company or organization, 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 health 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; individual 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; 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. The consent/authorization expires in 30 months.

Applicant:

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 spousal information described previously on this application.

APPLICANT'S SIGNATURE (Required)	SPOUSE'S SIGNATURE	DEPENDENT'S SIGNATURE (Required only if dependent is age 26-27)

Date _____


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