MAIL TO: AultCare Member Services
PO Box 6910
Canton, OH 44706
FAX: 330-363-7746
SERVICE: 330-363-6360 OR 1-800-344-8858
EMAIL: aultcareeligibility@aultcare.com

TODAY'S DATE: ____________________
COMPANY: ____________________
GROUP NUMBER: ____________________
COMPLETED BY: ____________________

MEMBERSHIP REPORT

EFFECTIVE DATE OF TRANSACTION	EMPLOYEE NAME LAST, FIRST, M.	ID NUMBER	TRANS. CODE	COVERAGE TYPE	COMMENTS

Please indicate all changes/updates on this report. Do not make changes on the monthly premium statement. Utilize transaction codes for each change. Include enrollment form where indicated and provide within 31 days of event. ***Signed enrollment forms must include spouse's signature when applicable.**

TRANSACTION CODES

Addition to Enrollment:

1. Addition (Include Enrollment Form) If enrollment is due to SCHIP loss of coverage, please indicate this in the Comments section.

1a. Special Election Period/Measurement Period Qualifying Event (Include Enrollment Form)

Change to Enrollment:

2. Change – Single to Family (Include Enrollment Form)
3. Change – Family to Single (Include Enrollment Form)
4. Change – Name/Address (Specify in Comments section, if name change & include Enrollment Form)
5. Change – Addition of Dependent (Specify in Comments section, include Enrollment Form)
6. Change – Deletion of a Dependent (Specify in Comments, include Enrollment Form with waiver section signed & Divorce Decree if applicable.)
7. Change – Other (Specify in Comments)

Form 1338 (93246) R: 6/15, 4/15, 11/11, 9/11, 6/10, 3/09

Cancellation of Coverage:

8. Cancellation – Left Employment/Termination (Include in Comments section Termination Date & if Voluntary, Involuntary or due to Gross Misconduct)
9. Cancellation – Deceased (Specify Date of Death in Comments section)
10. Cancellation – Layoff (Include in Comments section the Date of Layoff & if Voluntary or Involuntary)
11. Cancellation - Waiving (Specify in Comments if waiving coverage, include Enrollment Form with waiver section signed.)
12. Cancellation – Reduction in hours: no longer meets minimum eligibility requirements

Continuation of Coverage:

13. COBRA Coverage Elected (Include Expiration Date, Copy of signed election form & proof of first payment)
14. State Continuation of Coverage (For companies under 20 – please indicate expiration date of State Continuation of Coverage in the Comments section)

Other:

15. Other (Include detailed explanation)