Self Group Employee Application

Group# _____

Employee Name: _____

Company Name: _____

☐ New Company

☐ New Employee

☐ Change Group# _____

Effective Date _____

AULTRA

ADMINISTRATIVE GROUP

Aultra Administrative Group health plans provide you with comprehensive benefits, superior customer service and simplified claims filing. You can choose from a large network of physicians, specialists and hospitals to fit your health care needs.

You can count on Aultra's commitment to deliver high-quality health care, and we want to add you to the list of our extremely satisfied customers.

If you have any questions, please call Aultra Service Center at 1-855-270-8497 or visit us at www.aultragroup.com.

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

AULTRA 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 ☐ Life ☐ Short Term Disability ☐ Other

Aultra Effective Date

(1) COVERAGE INFORMATION

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
(Signature needed on last page)

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)
☐ Change Beneficiary (Complete Section 2 (Life) and sign Section 5 as an eligible employer)

*Upon your effective date with Aultra, please supply a letter of creditable coverage if applicable.

COBRA SECTION

Covered Under: ☐ Cobra
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	Sex: ☐ Male ☐ Female

E-mail Address:	Home Phone	Cell Phone (optional)

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

Employment Status Date of Hire: _____
Hours Worked per Week: _____
☐ Full-Time ☐ Part-Time ☐ Retired

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?

Life Insurance
Initial Class: _____ Amount: _____ Beneficiary: _____ Relationship: _____
Change Signature of Employee: _____ Date: _____

(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				/ /		/ /

If any of your eligible children live at a different address from yours, please list: 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 Aultra in the past 12 months? _____
If yes, please list employer group name the claims were paid through: _____

As of your effective date with Aultra, 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?

(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**

Name: **Group Name:**

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.

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 Aultra 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 Aultra 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 Aultra 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 Aultra 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.

Your Signature **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 **Date**

ADDITIONAL INFORMATION:

Per the 2015 FCC TCPA Ruling, AultCare Insurance Company, or a vendor on behalf of AultCare Insurance Company, may contact you for demographic, satisfaction, and/or medical care management information in accordance with its obligations under Federal Law.

AULTRA
ADMINISTRATIVE GROUP
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