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_____TO _____
   (mo./day/yr.) (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

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AULTCARE

Michelle's Law Notice- Public Law 110-381

Eligibility for Continued Coverage for Full Time Students on Medically Necessary Leave of Absence

Michelle's Law was enacted on October 09, 2009 and provides continued coverage under group health plans for dependent children who are covered under a group health plan as a full time student but lose their student status because they take a medically necessary leave of absence from school.
This law is effective for plans renewing on or after October 09, 2010. If your plan is a calendar year plan, the effective date is January 01, 2010.
As a result, if your dependent is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence.
This continued coverage applies if, immediately before the first day of the leave of absence, your child was:

1. covered under the plan, and
2. enrolled as a full time student at a post-secondary educational institution

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the child to lose full time student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence,
2. the date on which such coverage would otherwise terminate under the terms of the plan, and
3. stays the same as if your child had continued to be a covered full time student and had not taken a medically necessary leave of absence.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary through the Application for Continued Coverage process.