

Individual & Family PPO Plans Application

UNICARE 500, 1000, 1500, 2000
UNICARE Premier No Deductible
UNICARE Saver 2000



**Individual and Family
Plans**

Thank you for applying with UNICARE.

PLEASE NOTE:

- **Coverage is not available if:**
 - any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
 - the applicant has not resided in the U.S. for the last six (6) consecutive months.
- **Coverage is not guaranteed until approved in writing by UNICARE.**

Instructions

Do not complete this application until you have read the current product brochure.

Please follow these instructions to allow us to better process your application.

- For your own protection, **you, the applicant**, must complete this application. You are solely responsible for its accuracy and completeness.
- All information must be stated accurately.
- All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
- For additional information or explanations attach extra sheets, if necessary. **All attachments must be signed and dated.**
- Print clearly using black ink. No correction fluid, please. **Sorry, but typed applications will not be accepted.**
- This application must be received by UNICARE Medical Underwriting within thirty (30) days from the signature date.
- UNICARE Plans are available only in areas where the UNICARE Network exists. Please see Provider Directories for more details.
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the plan being rescinded.
- Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Part 8 – Conditions of Application)**
- Please return this application and your check to your agent OR mail to the appropriate address listed at right.

Billing Information

Carefully read the instructions accompanying each billing type and make sure that your check is attached to the application.

- **Monthly billing (with monthly bank draft authorization only):** Submit the one (1)-month premium, complete the Monthly Bank Draft Authorization and attach a blank check marked “VOID” to the form.
- **Quarterly billing:** Submit the three (3)-month (quarterly) premium.

Most common causes for delay in underwriting

- Missing, inaccurate or incomplete information such as:
 - Weight AND Height
 - Spouse’s social security number
 - Dependent’s social security number
 - Age AND date of birth
 - Date of last pelvic examination
 - Results of last pelvic examination
 - Physician address, phone number and fax number
- Incomplete or illegible information such as the mailing address does not include city, state, and ZIP code.
- ALL questions are not answered in Section 4, 5, 6 and 7. If it does not apply to you, the answer should be “No.” Do not leave any answers blank.
- The application is not signed and dated by the applicant and/or all dependents over age 18.
- Agent portion of application is not completed, signed, or dated with a date after applicant’s signature date.
- Additional documentation or information is required.

Mailing Address

- **Applicant:** Please return this application to the agent.
- **Agent:** Please mail this application to the address below. Select the P.O. Box based on state where applicant resides.

UNICARE Individual Services
(P.O. Box from below)

Bolingbrook, IL 60440

Illinois: P.O. Box 5021

Indiana: P.O. Box 5022

Virginia: P.O. Box 5024

New Applicant(s) Add Dependent(s)

1. Choice of UNICARE Coverage – Choose one plan per application.

Please print in black ink.

Plan choice: UNICARE: \$500 Deductible \$1,000 Deductible \$1,500 Deductible \$2,000 Deductible
 UNICARE Premier No Deductible: \$30 Copayment
 UNICARE Saver Plan: \$2,000 Deductible

Additional coverage: Term Life Insurance – Please include separate Life application addendum and additional premium with this application.
 Dental Plan option

Billing type: Monthly bank draft – One-month premium required. (Checking account deducted at the 1st of each month.)
 Quarterly billing – Three-months premium required.
 Summary Bill – Existing Summary No: _____ – Please attach Summary Bill cover sheet.

2. Applicant Information – Applicant must complete this application.

Height and weight must be stated accurately.

SEX	NAME: Last	First	M.I.	HEIGHT	WEIGHT	AGE	BIRTHDATE Month/Day/Year	SOCIAL SECURITY NO.	MARITAL STATUS	UNICARE USE ONLY			
<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Married <input type="checkbox"/> Single	WVR	DUR	WVR	DUR
RESIDENCE ADDRESS						BILLING ADDRESS							
Street Address						Street Address							
City / State / ZIP						City / State / ZIP							
Home Phone No. ()			Business Phone No. ()			In Care Of:							
Occupation			Name of Employer					Applicant/Spouse Maiden Name (If applicable)					

3. Spouse and Unmarried Applicants Applying for Coverage

Height and weight must be stated accurately.

Check one: Insure all eligible applicants Insure no one unless all are accepted for coverage.

RELATION	SEX	NAME: Last	First	M.I.	HEIGHT	WEIGHT	AGE	BIRTHDATE Month/Day/Year	SOCIAL SECURITY NO.	FULL-TIME STUDENT	UNICARE USE ONLY			
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No	WVR	DUR	WVR	DUR
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				

Have all listed applicants been residents of the U.S. for the last six (6) months? Yes No

4. Other Coverage – Please answer ALL of the following questions.

- A. Do you currently have, or has anyone to be insured had coverage in the past 18 months? Yes No
If yes, provide Name of Insured: _____ Insurance Carrier(s): _____
 Effective Date: _____ End Date: _____
Please attach the Certificate of Creditable Coverage from your prior health insurance carrier.
- B. If you answered “yes” to A above, do you agree to discontinue your current coverage if this application is accepted? Yes No
If no, explain: _____
- C. Has anyone on this application been insured by UNICARE in the last 5 years? Yes No
If yes, name of former UNICARE Insured: _____ Plan / ID No: _____ Group No: _____
 UNICARE Plan: _____ City / State: _____ Date Cancelled: _____
- D. If you have UNICARE Group coverage (*To be completed for each applicant*) –
 I certify that my UNICARE Group Coverage terminated/will terminate on (date): _____
 I do not wish to enroll in any available Conversion Agreement. I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.
- E. Has anyone identified on this application ever been declined, postponed, waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? Yes No
If yes, provide name of applicant, insurance company name and a brief explanation: _____
- F. Are any persons applying for coverage on this application eligible for Medicare benefits? Yes No
If yes, name of eligible person(s): _____
- G. Has anyone applying for coverage on this application filed a claim for disability or Workers’ Compensation within the past 18 months? Yes No
If yes, name of applicant: _____ Effective Date: _____ End Date: _____

5. Health History (Continued) Use additional sheet if necessary.

QUEST. #	FAMILY MEMBER	CONDITIONS / TREATMENT MEDICATION(S) PRESCRIBED	DATE OF ONSET/ CHECK-UP OR SURGERY Mo / Yr	RECOVERY DATE Mo / Yr	DEGREE OF RECOVERY / RESULT OF EXAM	NAME, PHONE NO. & FAX NO. OF PHYSICIAN OR HOSPITAL ADDRESS / CITY / STATE / ZIP CODE

B. Please provide information regarding the last doctor visit and/or physical examination for ALL family members you wish to cover.

FAMILY MEMBER	DATE OF VISIT	REASON FOR VISIT	RESULTS		NAME, PHONE NO. & FAX NO. OF PHYSICIAN OR HOSPITAL ADDRESS / CITY / STATE / ZIP CODE
			Normal	Abnormal (Explain)	

6. Medications – List all MEDICATIONS taken currently or within the last 12 months by any family member listed on this application. Use additional sheet if necessary.

FAMILY MEMBER	MEDICATION AND DOSAGE	ILLNESS FOR WHICH MEDICATION IS PRESCRIBED	DATE PRESCRIBED	DATE DISCONTINUED	NAME, PHONE NO. & FAX NO. OF PHYSICIAN OR HOSPITAL ADDRESS / CITY / STATE / ZIP CODE

7. Lifestyle

<p>1. Has any applicant ever smoked or used any tobacco products – such as: cigarettes, pipe, cigar, snuff, or chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Family member(s):</p> <p>Amount per day:</p> <p>Type of product:</p> <p>Date discontinued:</p>	
<p>2. Has any applicant used illegal, controlled drugs, or substances in the last 10 years or been diagnosed as chemically or alcoholic dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Family member(s):</p> <p>Type of product:</p> <p>Date ended:</p>	
<p>3. Has any proposed insured consumed alcoholic beverages in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Amount: A drink is 12 oz. of beer, or 6 oz. of wine, or 1 oz. of spirits.</i></p>	<p>Family member(s):</p> <p>Amount per day:</p> <p>Amount per week:</p> <p>Amount per month:</p> <p>Type of product:</p>	

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. No. of sheets attached

8. Conditions of Application

Applicant's Social Security No.

IMPORTANT: It is important that you carefully read and fully understand the following.

I, the undersigned, understand that under the UNICARE plan for which I am applying, I will be entitled to lesser benefits if I use a non-participating Hospital, Physician, or other provider, than if I use a UNICARE participating Hospital, Physician, or other provider.

All Applicants Age 18 and over must personally read, agree to, and sign the following. If an Applicant does not read English, the translator must sign and submit a statement of accountability for translating this entire application.

EFFECTIVE DATE

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If however, you would still like to request a specific effective date, we strongly recommend that you allow 60-75 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance, and will also prevent you from being required to pay for two policies.

PLEASE NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.

- I request that UNICARE assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.
- If UNICARE approves my application, please assign an effective date of 1st 15th of the month following approval.
- If UNICARE approves my application, please assign an effective date of 1st 15th of .
This date must be AFTER the signature date but not greater than 75 days from the signature date on this application.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, UNICARE WILL NOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES.

BILLING DATE

UNICARE premiums are due on the 1st of each month. Insureds with a mid-month effective date will be billed on a pro-rated basis to bring future due dates to the first of a month.

AGREEMENT (All applicants)

I, the undersigned, agree to the following:

1. I understand and agree to pay an application fee equal to the premium required with this application. This payment is only a deposit which will be returned if my application is denied, or applied to the premium charges if my application is accepted.
2. If my application for UNICARE coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by UNICARE that I am accepted.
3. I understand that UNICARE has the right to deny my application, and if it does so, I will be notified in writing and my application fees submitted will be returned.
4. **MINOR CHILDREN:** I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.
5. **DEPENDENTS AGE 18 AND OVER:** I represent that (1) my dependents age 18 and over have read this application, and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, especially Sections 5, 6, and 7 with my dependents 18 and over, and (3) all information contained in this application regarding dependents age 18 and over is complete and accurate.

I understand and agree that if UNICARE rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Cashing of my check by UNICARE does not constitute approval of my application.

6. If I am accepted, this application will become part of the agreement between UNICARE and myself.
7. UNICARE may request additional information, and this may delay processing of this application. If the health care provider bills for these services, UNICARE will determine payment, and I will be responsible for any difference.
8. **The selling agent has no authority to promise me coverage or to modify UNICARE underwriting policy or terms of any UNICARE coverage.**
9. **I alone am responsible for reading and accurately completing this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed on this application is eligible for benefits if any information on this application is false, incomplete or omitted. UNICARE may void all coverage from the original effective date of the agreement for such material misstatements or omissions.**

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. **If the responsible adult is not the natural parent, please submit court papers authorizing guardianship.**

PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse.

10. My UNICARE agent may receive copies of any correspondence about my medical history when correspondence is required.

(Continued on the following page)

For UNICARE Use Only

GROUP NO.	CERTIFICATE NO.	AGENT TAX I.D. NO.	EFFECTIVE DATE	X REF. CERT. NO.	<input type="checkbox"/> AA <input type="checkbox"/> AR	BY	DATE

8. Conditions of Application *(Continued)*

AUTHORIZATION

As permitted by law, I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide UNICARE, its agents, or employees, including my UNICARE agent or broker, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury, or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below through the life of the plan. A photocopy of this Authorization is as valid as the original. My authorized representative, UNICARE agent, or I am entitled to receive a copy of this form.

I have personally read and completed this application. I understand and agree to all the Conditions of Application and the Authorization (Part 8). I understand that coverage is subject to the provisions in the Conditional Receipt (Part 11). I understand that receipt of money with this application does not create UNICARE coverage. Coverage will come into effect only if this application is approved by UNICARE. I, the applicant, acknowledge that I have read and understand this Application in its entirety. I have received an outline of coverage.

SIGNATURES *(Required)* – **IMPORTANT: All signatures MUST include today's date.**

Applicant / Parent or Legal Guardian	Today's Date	Applicant's Spouse <i>(Required if applying for coverage)</i>	Today's Date
X		X	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
X		X	

9. To be completed by the UNICARE-Appointed Agent or Representative

INSTRUCTIONS

REMEMBER: Applications are not accepted if received after 30 days from signature date.

- **Your client must personally read and complete this application.** If your client does not read or write English, the Exception to Standard Application form, Part C, must be completed.
- If a legal guardian is other than the natural parents, indicate relationship and submit copy of court-appointed guardianship papers.
- If an under-age family member does not reside with the applicant, the custodial parent must complete the Exceptions to Standard Application form, Part C. The proposed insured may sign for financial accountability.
- Please answer all questions below after the applicant has completed the application.
 1. Are you aware of any information not disclosed on this application relating to the health, habits, or reputation of any person listed on this application which might have a bearing on the risk? **Yes** **No**
If yes, please indicate detailed information on a separate sheet of paper.
 2. Did you see the applicant (and spouse, if applying) at the time this application was executed? **Yes** **No**
If no, please explain: _____
 3. Did the applicant personally complete the application? **Yes** **No**
If no, an Exceptions to Standard Application form, Part C must be submitted with this application.
 4. Was a conditional receipt given? **Yes** **No**
Amount collected: \$ _____
 5. Was the Monthly Bank Draft Authorization form completed? *(only if applicable)* **Yes** **No**

Name of Regional Sales Manager _____

Name of Writing Agent <i>(Print name)</i>	Agent Tax I.D. No	Check one: <input type="checkbox"/> EIN <input type="checkbox"/> SS#	Phone No. ()
Address	City / State / ZIP Code		Fax No. ()
Signature of Writing Agent <i>(Required)</i>			Date <i>(Required)</i>
X			
Name of Sub-Agent <i>(Print name)</i>	Agent Tax I.D. No	Check one: <input type="checkbox"/> EIN <input type="checkbox"/> SS#	Phone No. ()
Address	City / State / ZIP Code		Fax No. ()
Signature of Sub-Agent <i>(Required)</i>			Date <i>(Required)</i>
X			

Mail Plan to: Broker / Agent Insured

PLEASE NOTE: If neither box is checked, the Plan will be mailed directly to the insured.

Applicant's Social Security No.

10. OPTIONAL Monthly Bank Draft Authorization

Complete this section and attach a blank check marked "VOID" to this form (DEPOSIT SLIPS ARE NOT ACCEPTABLE). Attach premium check. If the account listed below is a joint account, both account holder's signatures are required. ALL FUNDS ARE DRAWN ON THE FIRST OF EACH MONTH. Premiums may be pro-rated in order to adjust the initial paid to date or in the event of membership changes.

Applicant Name	
Applicant's Social Security No. / Insured No.	Group No.
Name on Checking Account (If different than above)	Checking Account No.

Name of Bank
Address
City / State / ZIP Code

AUTHORIZED SIGNATURE (As it appears in the financial institution's records)	DATE (Required)
X	
AUTHORIZED SIGNATURE (As it appears in the financial institution's records)	DATE (Required)
X	

OPTIONAL MONTHLY BANK DRAFT AUTHORIZATION

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of UNICARE Life & Health Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize UNICARE Life & Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my UNICARE premium. This authority is to remain in effect until revoked by me in writing. I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in forfeiture of insurance.

NOTE TO APPLICANT: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Bank Draft and be billed quarterly. To re-start deductions, a new authorization and void check will be required.

You will incur a service charge for any withdrawal not honored.

UNICARE must be notified of any changes to your bank account no later than the 20th of the month preceding the change.

11. Initial Premium Payment by Credit Card

Number of months premium: 1 month 2 months 3 months

Amount of initial premium: \$ _____

Credit card: (VISA or Mastercard only) VISA Mastercard

Card No.: _____

Expiration Date: _____

Cardholder's name: _____

Relationship to applicant: _____

Signature of cardholder: **X** _____

Today's Date: _____

Attach Check(s) Here

**ATTACH BLANK, VOIDED CHECK
FOR BANK DRAFT AUTHORIZATION,
IF APPLICABLE, HERE**

DO NOT TAPE

ATTACH PREMIUM CHECK HERE

DO NOT TAPE

12. Conditional Receipt – To be completed by the agent and given to applicant.

APPLICANT'S SOCIAL SECURITY NO.

Received from _____ \$ _____ as an application fee, payable to UNICARE.

Subject to the following:

IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE MONEY SUBMITTED WITH THIS APPLICATION IF THIS APPLICATION IS NOT APPROVED, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THIS APPLICATION IS APPROVED BY UNICARE.

Dated this _____ day of _____, 20_____.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By **X**

Signature of Agent

Agent Tax I.D. Number

**ALL CHECKS FOR APPLICATION FEES MUST BE MADE PAYABLE TO UNICARE.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.**

Notice of Information Practices

If you apply for or are covered by a UNICARE health care plan, UNICARE may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. For example, UNICARE may provide information to a hospital in order to verify benefits. Upon your request, UNICARE will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correction if you believe it to be inaccurate. UNICARE can choose to furnish the medical record information either directly to you or to a medical professional designated by you.