

QuotesforMedical.com

Application Instructions for Unicare

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to QuotesforMedical.com for review along with the completed application. If you do not have access to a fax machine, send the completed application to QuotesforMedical.com along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Unicare** if you are not paying by credit card for the first month.

Mail completed applications and check to:

QuotesforMedical.com
Attn: New Enrollment
100 W. Roosevelt Rd
Bldg 8, Ste 103A
Wheaton, IL 60187

QuotesforMedical.com will review your application for completeness and accuracy before we submit it to Unicare for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 1-866-522-5953 or e-mail us at info@QuotesforMedical.com.

Norvax form #IN-1

QuotesforMedical.com

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

QuotesforMedical.com

FAX# 630-480-3346

Dear QuotesforMedical.com,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____
after you have reviewed my application for completeness and accuracy.

I will contact QuotesforMedical.com at 1-866-522-5953 to verify receipt of my application.

****I understand that QuotesforMedical.com will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to QuotesforMedical.com. :

QuotesforMedical.com

Attn: New Enrollment

100 W. Roosevelt Rd

Bldg 8, Ste 103A

Wheaton, IL 60187

I will send the original, signed application and premium payment, as soon as I have been contacted by QuotesforMedical.com with confirmation that my application has been received by fax and reviewed for completeness.



INDIVIDUAL & FAMILY PPO HEALTH INSURANCE PLANS

UniCare FIT 500, 1000, 1500, 2000, 3000, 5000 Plans

UniCare Saver 2000 Plan, UniCare High-Deductible (HSA Compatible) Plans

LIFE AND DENTAL PLANS APPLICATION

Thank you for applying with UniCare Health Insurance Company of the Midwest (UniCare).

Please Note:

-Tobacco users and applicants with certain medical conditions pay an additional premium. For family applications, if any family member who is to be insured smokes or uses tobacco, or has a certain medical condition ("rated person(s)"), an additional premium will be applied to the rated person(s) and the entire family. To avoid the additional premium being applied to the remaining family members, you will have the option to have the rated person(s) placed on a different plan so that he or she is billed separately from the other family members'. See details under "Family Split Application Option" in Section 7.

• 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. Do not cancel your current insurance coverage until you have been notified of approval by UniCare and your UniCare coverage is effective.**

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 blue or black ink (no correction fluid, please).
- This application must be received by UniCare Medical Underwriting within thirty (30) days from the signature date.
- UniCare Health and Dental 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 intentional 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 Section 7 – Conditions of Application).**
- Please return this application and your choice of payment method to your agent, submit online OR mail to the address listed at right.

Billing Information

Carefully read the instructions accompanying each billing type and make sure that your payment is submitted with the application.

- **Monthly billing (with monthly bank draft authorization only):** Submit the one (1)-month premium; complete the Monthly Bank Draft Authorization.
- **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
 - 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 Sections 4 and 6. 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 on or 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.

**UniCare Health Insurance Company of the Midwest
Attn: UniCare Individual Services-Illinois
P.O. Box 5030
Bolingbrook, IL 60440-5030**

Or for overnight delivery:

**Attn: Individual Medical Underwriting Department
UniCare
220 Remington Blvd.
Bolingbrook, IL 60440-3509**

– Also available for online submission at www.unicare.com



UniCare Health Insurance Company of the Midwest

Applicant's Social Security No.									

INDIVIDUAL ENROLLMENT APPLICATION - ILLINOIS

- Application must be completed by the applicant in blue or black ink.
- Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.

1. Applicant Information (Please Print)

Primary Applicant's Last Name	First Name	M.I.
Home Address (Residence address required; P.O. Box not acceptable)		
City	State	ZIP Code

Reason for Application (Check one)

New Enrollment(s)
 Child only (Please use youngest child for primary applicant)
 Add dependent(s) to I.D. No: _____
 To change existing UniCare plan, please enter I.D. No: _____
 For Summary Bill (existing), I.D. No: _____

Mailing Address (If different from above) (P.O. Box or Personal Mail Box No.)	Home Phone No. ()	E-mail Address (Optional)
City State ZIP Code	Daytime Phone No. ()	Fax No. ()
In care of: (If applicable)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Spouse's Social Security No. (Required)
Employer	Maiden Name of Applicant/Spouse (If applicable)	
Occupation	Title	Business Phone ()

Billing Type: Monthly Bank Draft Quarterly Billing Summary Bill (Please attach Summary Bill cover sheet.)
 Have all applicants resided in the U.S. within the past six consecutive months? Yes No
 If no, please provide name and explain:

Language preference (Optional) English Spanish Korean Chinese Polish Other (Specify):
 Ethnic Code (Optional)

1 <input type="checkbox"/> Caucasian	3 <input type="checkbox"/> Black/African American	5a <input type="checkbox"/> Native American Indian	A <input type="checkbox"/> Amerasian	J <input type="checkbox"/> Japanese	N <input type="checkbox"/> Asian Indian	T <input type="checkbox"/> Laotian
2 <input type="checkbox"/> Hispanic	4 <input type="checkbox"/> Asian	5b <input type="checkbox"/> Alaskan Native	C <input type="checkbox"/> Chinese	K <input type="checkbox"/> Korean	P <input type="checkbox"/> Hawaiian	V <input type="checkbox"/> Vietnamese
		7 <input type="checkbox"/> Filipino	H <input type="checkbox"/> Cambodian	M <input type="checkbox"/> Samoan	R <input type="checkbox"/> Guamanian	Z <input type="checkbox"/> Other

2. Choice of UniCare Individual Coverage

<input type="checkbox"/> FIT 500 (BK77)	<input type="checkbox"/> FIT 3000 (BK81)	<input type="checkbox"/> HSA Compatible Variable-Deductible Plan (T779)	<input type="checkbox"/> Life
<input type="checkbox"/> FIT 1000 (BK78)	<input type="checkbox"/> FIT 5000 (BK82)	<input type="checkbox"/> HSA Compatible (\$2,600/\$5,200) Plan 2 (T083)	<input type="checkbox"/> Dental
<input type="checkbox"/> FIT 1500 (BK79)	<input type="checkbox"/> UniCare Saver 2000 (G846)	<input type="checkbox"/> HSA Compatible Variable-Contribution Plan (X442)	
<input type="checkbox"/> FIT 2000 (BK80)		<input type="checkbox"/> HSA Compatible (\$5,000/\$10,000) Plan 3 (T084)	
		<input type="checkbox"/> Other _____	

3. Applicants for Coverage

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

Please list all applicants applying for coverage. (List children youngest to oldest.)

If a family member's last name is different than yours, please attach explanation to application.

Relation	Last Name	First Name	M.I.	MUST BE ACCURATE		Date of Birth	Social Security No.	✓ Full Time Student	FamilyFlex® List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY	
				Height	Weight						WVR	WVR
<input type="checkbox"/> Male <input type="checkbox"/> Female	Yourself											
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse											
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												

FOR UNICARE USE ONLY - DO NOT WRITE BELOW

Group No.	Certificate No.	Agent I.D. No.	Effective Date	X Ref. Cert. No.	<input type="checkbox"/> AA <input type="checkbox"/> AR
By	Date				10118IL 10/06

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 last 18 months? Yes No

If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

Name of Insured(s)	Insurance carrier(s)	Effective date	End date
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Do you agree to discontinue your current coverage if this application is accepted? Yes No

If No, please explain:

B. Has anyone on this application been insured by UniCare in the last 5 years? Yes No

If Yes, please provide the following information.

Name of Insured(s)	Plan/I.D. No.	Group No.	
Name of Plan	City	State	Date cancelled

C. If any applicant has/had UniCare group coverage, please complete the following:

I certify that my UniCare group coverage will end/ended 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.

D. Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? Yes No

If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain
3. Name of applicant	Name of Insurance Company	Explain

E. Are any persons applying for coverage on this application eligible for Medicare benefits? Yes No

If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.

Eligible person(s)

F. 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, please provide the following information.

Name of applicant	Effective date	End date
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5. Term Life Insurance

Applicants must meet UniCare's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. **Submit Premium with application.**

Name of Family Member	✓ Amount of Coverage			Name of Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP Code
	\$15,000	\$25,000	\$50,000*			
Primary Applicant						
Spouse						
Dependent						

*The \$50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to \$25,000.

**If a beneficiary is not listed and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

6. Health History - Include information on all family members you wish to enroll.**6A. Health History Questionnaire - ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.**

Has any person listed on this application had a clear, distinct symptom that would cause an ordinarily prudent person to seek advice or treatment, or had treatment or consultation recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **within the last 10 years**:

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis, or any other neurological or central nervous system disorder(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Male applicant(s) a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, or implant <input type="checkbox"/> Yes <input type="checkbox"/> No b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy, or any similar symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Female applicant(s) a) Breast disorder/cyst, lump, fibroid tumors, silicone injections, or implants <input type="checkbox"/> Yes <input type="checkbox"/> No b) Pelvic pain, menstruation disorders, abnormal pelvic exam/Pap smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No c) Date and result of last pelvic exam/Pap smear for each female over 16: Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal d) Is the applicant, spouse or any female dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, or any other circulatory condition <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, reactive airway disease (RAD), pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Diseases or problems of the ears or hearing, implant, or hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, or use of a sleep monitoring device <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, or any other digestive disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain, or hepatitis (indicate type: _____) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application ever : 25. Had cancer, tumor/growth, leukemia, or cyst? <input type="checkbox"/> Yes <input type="checkbox"/> No 26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery, or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No	27. Seen, been a patient in a hospital, clinic, or other medical facility, including wellness visits and routine exams, received treatment from or consulted any doctor or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio, or any other musculoskeletal disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	28. Been diagnosed or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation, or prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Diabetes, thyroid, pituitary, adrenal, elevated cholesterol or any other metabolic endocrine disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery, or any other skin conditions <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Sexually transmitted disease, such as herpes, genital warts, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No	

IMPORTANT: Applicant's medical conditions, which occur after the signature date and before the approval date that come to UniCare's attention, may be considered in the final underwriting decision.

6B. Professional Services

Applicant's Social Security No.									

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		<input type="checkbox"/> Still under treatment	Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed	Date Discontinued	

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		<input type="checkbox"/> Still under treatment	Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed	Date Discontinued	

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		<input type="checkbox"/> Still under treatment	Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed	Date Discontinued	

6C. Prescription Medications

List all medications not noted above taken within the last 12 months by any family member listed on this application.

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

6D. Other Health Questions

1. Has any applicant ever smoked or used any tobacco products, such as: cigarettes, cigars, pipe, snuff, or chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member	Amount per day	2. Family member	Amount per day
	Type of product	Date Discontinued	Type of product	Date Discontinued
2. Has any applicant used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, in the last 10 years, or been diagnosed as chemically or alcohol dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant ever used any illegal or controlled I.V. drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has any applicant consumed any alcoholic beverages in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.</i>	1. Family member		2. Family member	
	Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month		Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member	Date Discontinued	2. Family member	Date Discontinued

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

7. Conditions of Application

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

Applicant's Social Security No.

I, the undersigned, understand that under the UniCare plan for which I am applying, I may be entitled to lesser benefits if I use a non-participating hospital, physician, or other provider, than if I use a UniCare independently contracted 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 the Statement of Accountability, Section 11, 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 like to request a specific effective date, we strongly recommend you allow 60-75 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance and will prevent you from being required to pay for two plans. Please note that surrendering your other coverage prior to approval of a UniCare plan could result in no coverage if the UniCare application is denied. NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.

If UniCare approves my application, please assign an effective date of the first day after UniCare's approval.

If UniCare approves my application, please assign an effective date of the

1st of the month following approval.

_____ (mm/dd/yy).

The effective 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, ONLY UNICARE CAN CHANGE THIS DATE. ONCE THIS CERTIFICATE OF COVERAGE IS ISSUED, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES.

Initial _____

Billing Date

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

Family Split Application Option

UniCare offers different levels of premiums. Applicants with certain medical conditions may be offered coverage at a higher rate or tier.

The rating tier offered is determined during the underwriting process. Although each family member on the application is underwritten individually, the rating tier is applied to the entire family plan.

However, if you choose, you have the option to "split" the application. If you choose this option, once it has been determined that one or more applicants will be placed into a higher rating tier, the application will be split with the rated person(s) on one application and any remaining applicants processed separately.

This split may result in separate effective dates, separate billing and in the case of family applications, premium differences. In addition, if more than one plan is issued, separate annual family deductible and out-of-pocket maximums must be satisfied. For purposes of the HSA Compatible plans, multiple plans may result in a lower contribution maximum into a Health Savings Account. Please contact your tax advisor if you plan on opening a Health Savings Account to use in conjunction with the HSA Compatible plan that you are applying for under the Family Split Application Option.

If, after due consideration and discussing these options with your agent you would like to take advantage of this offer, please initial below.

I have read the above and understand that in initialing this I accept that in the event that one or more persons on my application is placed into a higher rating tier that my application will be split and, if approved, more

than one plan will be issued. I have discussed this option with my agent and understand that my monthly premium, annual deductible, and annual out-of-pocket maximum may be affected. In addition, I understand that my family and I may receive separate bills and different plan effective dates.

INITIALS OF APPLICANT _____

DATE _____

Agreement (All applicants)

I, the undersigned, agree to the following:

1. I understand and agree to pay the premium required with this application. This payment is 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 my application is approved.
3. I understand that UniCare has the right to deny my application, and if it does so, I will be notified in writing and the premium payment will not be processed.
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. **CONCERNING DEPENDENTS AGE 18 AND OVER:** I represent that my dependents age 18 and over (1) 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 6A, 6B, 6C and 6D with them, and (3) agree that all information contained in this application regarding them is complete and accurate.
6. 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. Receipt of money, cashing of my premium check or charging my credit card by UniCare does not constitute approval of my application or create UniCare coverage.
7. If I am accepted, this application will become part of the agreement between UniCare and myself.
8. UniCare may need to request additional medical information from your provider, and this may delay processing of this application. If the health care provider charges a fee for providing this information, UniCare will determine payment, and I will be responsible for any difference.
9. I understand UniCare in considering my application, may use any information prior to the effective date of coverage including medical conditions which occur after the signature and before the original effective date.
10. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.
11. I have personally read and completed 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 is eligible for benefits if any information on this application is false, incomplete or omitted. UniCare may void all coverage for all persons listed on the application from the original effective date of the agreement for such material intentional misstatements or omissions. Any fraud or misstatements on the application may lead to rescission of the plan and, if applicable, possible disqualification of the HSA and adverse tax implications.
If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.
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 Authorization accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.
12. My UniCare agent may receive copies of any correspondence about my medical history when correspondence is required.

Authorization

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider ("My Providers") that has provided payment, treatment or services to me or any of my dependents who are also applying for coverage to disclose entire medical records, prescription history, medications prescribed and any other protected health information concerning me or any of my dependents who are also applying for coverage with UniCare, including UniCare or its designated agent. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I acknowledge that any agreements made to restrict protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that UniCare may: 1) underwrite my application for coverage, make eligibility, risk rating, plan issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UniCare.

This authorization shall remain in force for 36 months following the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or any of my dependents who are also applying for coverage or to the extent that UniCare has a legal right to contest a claim under an insurance plan or to contest the plan itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by UniCare except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release complete medical records, UniCare may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative, UniCare designated agent or I will receive a copy of this authorization upon request.

I understand and agree to all the Conditions of Application (Section 7). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 12). I have read and understand this Application in its entirety.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse <i>(required if applying for coverage)</i>	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

**IF PAYING BY CHECK, ATTACH INITIAL PREMIUM CHECK HERE.
DO NOT TAPE.**

Applicant's Social Security No.									

8. Payment Method – Submit premium payment with application (required). When you send your check to us, you authorize UniCare to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

8A. Initial Premium Payment – Select one of the following payment options. Initial payment will be credited to approved applicants only.

I have attached a separate check for the initial premium.

Please charge my credit card. Complete credit card information below.

Please process an electronic check. Complete electronic check information below. Business checks are not acceptable.

Credit Card Information Select one: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months		Electronic Check Information Select one: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	
Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard	Initial Premium Amount \$	Check No. (for initial premium payment)	Initial Premium Amount \$
Credit Card No.	Expiration Date	Bank/Credit Union Routing No.	
Cardholder's Name	Cardholder's Zip Code	Checking Account No. (as it appears on your check)	
Authorized Signature (as it appears on the credit card) Today's Date		Name on Account	

8B. Payment Type – Select one of the following payment types.

Quarterly Billing
Submit the three month premium.

Monthly Billing (Available with Monthly Checking Account Deduction.)

- Submit the one month premium.
- Complete section 8C, Monthly Checking Account Deduction Authorization.
- Please choose the draft date in which you would like your premium debited from your checking account:
 1st 8th 15th 22nd of each month.
- If your application is approved, the premium for all products selected, including dental and/or life will be deducted monthly from your checking account.

8C. Monthly Checking Account Deduction Authorization (Complete only if you selected Monthly Billing in 8B above.)
UniCare must be notified in writing of any changes to your bank account at least 10 days prior to your monthly bank draft bill date.

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 provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights with respect to each debit will be the same as if it were a check drawn on you and signed personally by me. I authorize UniCare 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, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option. **You will incur a \$25 service charge for any withdrawal not honored.**

Applicant Name	Applicant Social Security No.	Name on Checking Account	
Name of Bank or Financial Institution/Address/City/State/Zip Code			
Bank/Federal Credit Union Routing No.	Checking Account No. (as it appears on your check)	Authorized Signature (as it appears in the financial institution's records)	Date

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

Received from _____ \$ _____ as a premium amount, payable to UniCare.

Subject to the following:

IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE 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. IF YOU DO NOT QUALIFY FOR COVERAGE, YOUR INITIAL PREMIUM PAYMENT WILL NOT BE PROCESSED. IF YOUR PREMIUM PAYMENT IS PROCESSED IN ERROR, A REFUND WILL BE ISSUED.

Dated this _____ day of _____, 20 _____.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By **X** _____

Signature of Agent

Agent I.D. Number _____

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. UniCare may also provide information to a health care provider 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 correct that information 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.