

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.



UniCare Life & Health Insurance Company

Applicant's Social Security No.								

INDIVIDUAL ENROLLMENT APPLICATION - MICHIGAN

- Application must be completed by the applicant in blue or black ink.
- Any family member currently pregnant or expecting a child (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. ()	Best Time To Call:
City	State	ZIP Code	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 ()	
E-mail Address (Optional)	If possible, do you want email notification? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Have all applicants resided in the U.S. for the past six consecutive months? Yes No

If no, please provide name and explain:

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	

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				

MIIAPP0507

14588MI 8/07

2. Choice of UniCare Individual Coverage

- | | | |
|--|--|--|
| <input type="checkbox"/> MI FIT 500 (DZ41) | <input type="checkbox"/> UniCare Solaura SM HSA Plan 1a* (DY82) | <input type="checkbox"/> UniCare High-Deductible Plan 1 – 80% (X437) |
| <input type="checkbox"/> MI FIT 1000 (DZ42) | <input type="checkbox"/> UniCare Solaura SM HSA Plan 2a* (ED92) | <input type="checkbox"/> UniCare High-Deductible Health Plan 2 – 80% (X439) |
| <input type="checkbox"/> MI FIT 1500 (DZ43) | <input type="checkbox"/> UniCare Solaura SM HIA Plus 1 (ED93) | <input type="checkbox"/> UniCare High-Deductible Health Plan 3 – 100% (X440) |
| <input type="checkbox"/> MI FIT 2000 (DZ44) | <input type="checkbox"/> UniCare Solaura SM HIA Plus 2 (ED94) | <input type="checkbox"/> UniCare High-Deductible Health Plan 4 – 100% (X438) |
| <input type="checkbox"/> MI FIT 3000 (DZ45) | <input type="checkbox"/> UniCare Solaura SM HIA Plus 3 (ED95) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> MI FIT 5000 (DZ46) | <input type="checkbox"/> UniCare Solaura SM HIA 1 (ED96) | <input type="checkbox"/> Life (Y440) |
| <input type="checkbox"/> UniCare Saver 2000 (X436) | <input type="checkbox"/> UniCare Solaura SM HIA 2 (ED97) | <input type="checkbox"/> Dental (Y441) |

* For UniCare SolauraSM HSA Plans, please complete the following:

- Yes, I do want to establish a Health Savings Account with UniCare's banking partner. Please forward my information to UniCare's banking partner. I understand that this includes my name, address, and social security number. (SSN required)
- No, I do not want to establish a Health Savings Account with UniCare's banking partner. Please do not forward my information to UniCare's banking partner.

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												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												

Applicant's Social Security No.

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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. List all carriers and use additional sheets if necessary.

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:

Has any applicant had coverage in the last 63 days? Yes No

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):

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

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 or diagnosed with any of the following conditions listed in questions 1 through 24 **within the last 10 years:**

<p>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</p>	<p>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</p>
<p>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</p>	<p>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, including, but not limited to, irregular periods or menstrual cycles, 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</p>
<p>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</p>	<p>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</p>
<p>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</p>	<p>21. Diseases or problems of the ears or hearing, implant or hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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), chronic obstructed pulmonary disease (COPD), tuberculosis, emphysema, or any other respiratory disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>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</p>
<p>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</p>	<p>23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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</p>	<p>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</p>
<p>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</p>	<p>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, treatment or further evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain or hepatitis (indicate type: _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor or other person providing health care services for any other condition or symptom(s) (excluding childbirth), including wellness visits and routine exams, not listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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</p>	<p>28. Been diagnosed as having 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</p>
<p>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</p>	
<p>12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation or prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>13. Diabetes, thyroid, pituitary, adrenal, elevated cholesterol or any other metabolic endocrine disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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</p>	
<p>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</p>	
<p>17. Sexually transmitted disease, such as herpes, genital warts, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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 or prescribed 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 Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	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

8. I certify that my employer will not, directly or indirectly, contribute to any premium payments for this plan, including through a health reimbursement arrangement (HRA) or Internal Revenue Code 125 Plan (cafeteria plan).
9. 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.
10. I understand that in considering my application, UniCare may use any information pertinent to this application, including medical conditions that occur after the signature date and before the original effective date.
11. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.

12. 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 policy 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.
13. 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, diagnostic or other health care 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 Life & Health Insurance Company (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 and/or its affiliates may: 1) underwrite my application for coverage, make eligibility, risk rating, policy 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 policy or to contest the policy 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.

I UNDERSTAND THAT THE POLICY APPLIED FOR WILL NOT PAY BENEFITS FOR ANY LOSS INCURRED DURING THE FIRST 12 MONTHS AFTER THE ISSUE DATE ON ACCOUNT OF DISEASE OR PHYSICAL CONDITION WHICH I NOW HAVE OR HAVE HAD IN THE PAST.

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

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse (required if applying for coverage)	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

Applicant's Social Security No.									

9. Are you applying for UniCare medical coverage through a UniCare-appointed agent? Yes No

10. To be completed by your UniCare-Appointed Agent

<ul style="list-style-type: none"> 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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If no, please explain: _____</p>		<ul style="list-style-type: none"> Breakdown of premium collected: <p>Total Medical premium \$ _____</p> <p>Total Dental premium \$ _____</p> <p>Total Life premium \$ _____</p> <p>Total premium collected \$ _____</p>	
<ul style="list-style-type: none"> I verify that this application was completed by the applicant unless the Statement of Accountability (Section 11) was completed..... <input type="checkbox"/> Yes <input type="checkbox"/> No 		<ul style="list-style-type: none"> Was the Monthly Checking Account Deduction Authorization (Section 8B) completed? (only if applicable)..... <input type="checkbox"/> Yes <input type="checkbox"/> No Was a Conditional Receipt given?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	
Name of Writing Agent (Print Name) Mike Novelli		Name of Agency (Print name)	
Agent I.D. No. bhhlrjkqpz	Sub-Agent I.D. No.	Agency I.D. No.	
Writing Agent's Street Address/Suite or Personal Mail Box No. 100 W. Roosevelt Rd, Bldg 8, Ste 103A, Wheaton, IL 60187		Agency Address	
City/State/ZIP Code Wheaton, IL 60187	Location No.	Agency City/State/ZIP Code	
Phone No. (866) 522-5953	Fax No. (630) 480-3346	Agency Phone No. ()	Agency Fax No. ()
E-mail Address of Writing Agent info@QuotesforMedical.com		E-mail Address of Writing Agency	
Signature of Writing Agent (Required)	Date (Required)	Signature of Writing Agency	Date
RSM Name			
<p>Mail Plan to: <input type="checkbox"/> Agent <input type="checkbox"/> Primary Applicant</p> <p>PLEASE NOTE: If neither box is checked, the Plan will be mailed directly to the primary applicant.</p> <p>Mailing address: Agent, please mail this application to: UniCare, P.O. Box 5030, Bolingbrook, IL 60440-5030</p> <p>For overnight delivery: UniCare – Attn: Individual Medical Underwriting Department 233 S. Wacker Drive, Suite 3900, Chicago, IL 60606-6309</p>			

11. Statement of Accountability – To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:

Applicant does not read English Applicant does not speak English

Applicant does not write English Other (explain): _____

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Application (Section 7)."

By X _____ Today's Date (Required)

Signature of Translator

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.

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 provide information to a healthcare 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.