



## Your Individual Application Kit is Enclosed

### Thank You for Applying with UniCare.

If you are electing a UniCare Consumer Choice PPO plan you have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas.

If you choose this standard health benefit plan, please consult with your insurance agent, if applicable, to discover which state-mandated health benefits are excluded in this policy. Texas regulations require that you complete and submit a Consumer Choice Disclosure Notice at the time of application and annually thereafter.

#### 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 policy so that he or she is billed separately from the other family members. See details under "Family Split Application Option" in Section K.
- **Coverage is not available if:**
  - Any family member is currently pregnant (whether or not listed on the application) or in the process of adoption;
  - Any person listed on the application has not resided in the U.S. for the last three consecutive months; or
  - Any person listed on the application is eligible for Medicare.
- **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 the instructions below to allow for better processing of 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) unless you are completing the application online in which case we will accept a typed application.
- 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 K – Significant Terms, Conditions and Authorizations).**
- Please return this application and your choice of payment method to your agent, submit online or mail to the address identified in the Mailing Address section.
- **Please include a separate \$25 nonrefundable application fee.** Only one application fee is required for families submitting more than one application at the same time in the same envelope. The application fee is waived for applications submitted through a UniCare-supported online process.

## Instructions (continued)

- **If you make changes while completing this form or cross out something you wrote, be sure to initial those changes.**
- If any corrections are needed or the form is incomplete, the application may have to be returned to you, or we may try to contact you to obtain the necessary information. In that case, we will record your information on a form that will be attached to the application.
- You may request an effective date of any day of the month after the date we receive your application. Your application must be received by UniCare by the requested effective date in order to secure that date.

## Billing Information

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

- **Automatic Bank Draft (with monthly bank draft authorization only):** Submit check, or pay your first month premium by bank draft. You must complete the Monthly Bank Draft Authorization section of this application.
- **Quarterly billing:** Submit the three 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
  - Physician address, phone number and fax number
- Incomplete or illegible information such as the mailing address not including city, state and ZIP code.
- ALL questions are not answered in Sections I and J. If a question 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, spouse, and/or all dependents over age 18 (if applicable).
- Agent portion of application is not completed, signed, or dated with a date on or after applicant's signature date (if applicable).
- Additional documentation or information is required.
- Failure to include a \$25 nonrefundable application fee.

## Mailing Address

- **Applicant:** Please return this application to your agent (if applicable).
- **Agent:** Please mail this application to the address below:  
**UniCare Life & Health Insurance Company**  
**Attn: Individual Medical Underwriting Department**  
**P.O. Box 5030**  
**Bolingbrook, IL 60440-5030**

Or for overnight delivery:

**UniCare Life & Health Insurance Company**  
**Attn: Individual Medical Underwriting Department**  
**233 S. Wacker Drive, Suite 3900**  
**Chicago, IL 60606-6309**

- Also available for online submission at [www.unicare.com](http://www.unicare.com)



**Section C – Spouse to be Covered Information** (All fields required.)

Last Name	First Name	M.I.	Relationship <input type="checkbox"/> Spouse		
Social Security Number*	Height (Ft./In.) /	Weight (Lbs.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth (MM/DD/YY) / /

FamilyFlex® Health Plan Code (see Section E) | | |

**Section D – Child Dependents to be Covered Information**

(All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all child dependents to be covered under this coverage.  
(List all dependents beginning with the youngest.)

First, M.I. (last name if different)	Social Security Number*	Sex	Age	Date of Birth (MM/DD/YY)	Height (Ft./In.)	Weight (Lbs.)	FamilyFlex® Health Plan Code (see Section E)
		<input type="checkbox"/> M <input type="checkbox"/> F		/ /	/		
		<input type="checkbox"/> M <input type="checkbox"/> F		/ /	/		
		<input type="checkbox"/> M <input type="checkbox"/> F		/ /	/		
		<input type="checkbox"/> M <input type="checkbox"/> F		/ /	/		
		<input type="checkbox"/> M <input type="checkbox"/> F		/ /	/		

\*This information is used for internal purposes only and will not be disclosed.

**Section E – Medical Coverage Selection**

You may select a different health plan for each family member by using the FamilyFlex® option. To do so, refer to the four digit health plan codes in parenthesis below and indicate your health care coverage choices in Section B for Applicant, Section C for spouse, and Section D for all child dependents.

**Choice of UniCare Individual Coverage**

- UniCare Solaura® HSA Plan 1a\*\* (Z177)
- UniCare Solaura® HSA Plan 2a\*\* (Z178)
- UniCare Solaura® HSA Plan 3a\*\* (008S)
- UniCare Solaura® HIA Plus 1 (Z181)
- UniCare Solaura® HIA Plus 2 (Z182)
- UniCare Solaura® HIA Plus 3 (Z183)
- UniCare Solaura® HIA 1 (Z179)
- UniCare Solaura® HIA 2 (Z180)
- Enhanced FIT \$1,000 (Z118)
- Enhanced FIT \$1,500 (Z119)
- Enhanced FIT \$2,500 (Z120)
- Enhanced FIT \$3,500 (Z121)
- Enhanced FIT \$5,000 (Z122)
- Enhanced FIT \$10,000 (008M)
- Enhanced FIT \$15,000 (008N)
- Enhanced FIT \$20,000 (008P)
- Saver \$2,000 (Z169)
- Saver \$5,000 (008Q)
- Saver \$10,000 (008R)

**MHealth Insured  
(Houston Only)**

- HSA-Compatible Variable Deductible Plan\*\* (Z188)
- HSA-Compatible (\$2,600/\$5,200) Plan 2\*\* (Z189)
- HSA-Compatible Variable Contribution Plan\*\* (Z191)
- HSA-Compatible (\$5,000/\$10,000) Plan 3\*\* (Z190)
- Consumer Choice \$1,000 (Z185)
- Consumer Choice \$2,000 (Z186)
- Consumer Choice \$5,000 (Z187)
- Elect \$1,000 (Z525)
- Elect \$2,000 (Z526)
- Elect \$5,000 (Z527)
- Elect Basic \$2,000 (Z524)
- Elect Plus \$1,000 (Z528)
- Elect Plus \$1,500 (Z529)
- Elect Plus \$2,500 (Z530)
- Elect Plus \$3,500 (Z531)
- Elect Plus \$5,000 (Z532)
- Elect HSA-Compatible Variable Deductible Plan 1 (Z548)
- Elect HSA-Compatible Variable Contribution Plan 2 (Z549)

\*\* For UniCare HSA Plans, please select 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 (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.

### Section F – Dental Coverage Selection

- Dental (H031)**
- Applicant only
  - Spouse only
  - Child(ren) only
  - Spouse and children listed only
  - Applicant, Spouse, and all dependent children listed
  - Applicant and Spouse only
  - Applicant and all dependent children listed only
- Yes, if myself or any listed family members are declined for medical coverage, **still enroll all family members selected above for dental coverage, if eligible.**

### Section G – Term Life Insurance Selection

**Term Life**

Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).

Do you, the applicant, have any existing life policy or annuity contract? (Answer by checking one)

Yes  No

**If you answered “Yes” to the above question, inform the agent, if any, who will provide you an “Important Notice: Replacement of Life Insurance or Annuities,” which you must read and complete.**

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy or annuity contract? (Answer by checking one)

Yes  No

**Provide information below.**

Applicants must meet UniCare Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. All Term Life policies terminate at age 65.

Applicants	Coverage Amount (select one)*	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP code
<input type="checkbox"/> Applicant	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	Primary:		
		Contingent:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	Primary:		
		Contingent:		
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	Primary:		
		Contingent:		

\* Amounts above \$25,000 are 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.

## Section H – Billing Options

**Premium payment and nonrefundable \$25 application fee required with application. Please choose initial payment method from section 1 and ongoing payment method from section 2.** The application fee is waived for applications submitted online, through a UniCare-supported online process. Only one application fee is required for families submitting more than one application at the same time.

### 1. INITIAL PREMIUM

The premium amount may change during the underwriting process as a result of being placed into a higher rating tier, which will cause your initial and ongoing premium payment amounts to be at the higher premium rate.

Total amount enclosed/charged \$ \_\_\_\_\_

- Check Enclosed (If paying by check, make the check payable to UniCare. This option is not available when applying on the internet.)\*
- Electronic Check (first payment only; complete Section 1A)
- Bank Draft (complete Section 2B)
- Credit Card (complete Section 2C)

**A. Electronic Check** — In lieu of sending a paper check, we can submit the same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use. Business checks are not acceptable.

**Select One:**  1 month and \$25 Application Fee  3 months and \$25 Application Fee

Name on Checking Account (PRINT)	Bank Routing No.	Checking Account No.	Total Amount: \$	Check No.
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### 2. METHOD

- A. Home** — If you choose ongoing quarterly paper billing, a \$5 administrative fee will apply to each paper bill. Quarterly bills will be sent to your mailing address unless a separate billing address is listed below.

Name	Address (street and P.O. Box if applicable)	City	State	Zip
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- B. Automatic Bank Draft (automatic monthly premium withdrawals)** — By providing your check information, you authorize us to electronically debit your bank account. If you have not sent in an initial payment, your bank account will be debited one month's premium the day after approval. This will include all products selected, including dental and/or life and the non-refundable \$25 application fee. Subsequent premium amounts will be debited from your checking account on the day you request below.

Deduct money from my/our account for (check one):

- My first and ongoing payments  My ongoing payments only (first payment made by other manner)

**I authorize UniCare to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify UniCare in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand UniCare and my financial institution have the right to discontinue the withdrawals if they wish to do so.**

Account holder's name (please print) <b>X</b>	Account holder's signature (if other than the applicant) <b>X</b>
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**Requested Debit Day:**  1st  8th  15th  22nd of each month

If no date is requested, your premiums will be debited on the first of each month. If you select a draft date other than the first, premiums will be debited a month in advance (prior to the due date).

Provide your bank routing and account numbers here.

Bank Routing No.	Bank Account No.
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J. L. Webb 123 Main Street Anytown, USA 12345	DATE _____ 1175
PAY TO THE ORDER OF	\$ _____ DOLLARS
<b>SAMPLE</b>	
MEMO	_____
⑆123456789⑆1234567890123⑆1175	

\*By sending your paper check, you authorize UniCare to convert your check into a one-time electronic funds 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. Not available for applications submitted online. Business checks are not eligible for electronic processing.

**Section H – Billing Options** (continued)

**C. If Paying by Credit Card** — A credit card can be used only for the initial premium payment.  
 Select one:  1 month  3 months  
**Charge my credit card for (check one):**  
 1st payment  
**If applicant is using the credit card of another cardholder:** By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.  
**Credit card information —**  
 Cardholder's Name (as shown on the credit card): \_\_\_\_\_ Cardholder's Address: \_\_\_\_\_  
 Type of Credit Card:  VISA  MasterCard  
 Credit Card Number: \_\_\_\_\_ Exp. Date (MM/YY): \_\_\_\_\_  
**Authorization:** I authorize UniCare to charge the credit card indicated **Premium Payments**.  
 Applicant's Signature:  
**X** \_\_\_\_\_

**D. New List Bill** — Billing through third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).

**E. Change to Existing List Bill**  
 List Bill Arrangement Number: \_\_\_\_\_

**Section I – Other Health Coverage**

Are you or anyone applying for coverage currently eligible for Medicare?  
 Yes  No  
 If yes, give name(s). Please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.  
 \_\_\_\_\_

Did you or your eligible dependents have creditable coverage within the past 63 days?  
 Yes  No

**Please provide the following information for health insurance coverage during the previous 18 months. Attach a separate sheet if necessary.**

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Policy/Identification Number(s) (Optional)
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Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
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Will you be canceling any existing coverage if approved for UniCare coverage?  
 Yes  No

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)  
 \_\_\_\_\_

Name of Plan	City	State	Date cancelled
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**Section I – Other Health Coverage** (continued)

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	Explain
2. Name of applicant	Explain
3. Name of applicant	Explain

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	Claim effective date	Claim end date
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**Section J – Health History (IMPORTANT: This section has two steps)**

- STEP 1:**
- **Health history questions must be answered for every applicant or the application may be returned and/or rejected. Every applicant over age 18 must answer his/her own health history questions.**
  - **Give complete details in Step 2** for all questions answered "Yes".

**NOTICE TO ALL APPLICANTS LISTED ON THIS APPLICATION:** You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you and any eligible dependents are eligible for coverage. If you are unsure of your current or eligible dependents' medical condition, we strongly recommend that you ask the applicable physician(s) or other health care providers to clarify the specific condition. We have the right to review all medical records to verify the accuracy of the information during the first 24 months of coverage. However, do not assume we will review all applicable medical records before approving your application. If we issue coverage and later discover that you intentionally misrepresented or omitted information you knew in response to a question, we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review medical records or seek medical confirmation of your or any eligible dependents' health information as part of processing your application. You must fully disclose and answer all health history questions, even if you currently have health insurance coverage or had prior coverage with UniCare.

**Health History Questions – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section J, you must give complete details in Step 2 .**

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 26 **within the last 10 years**:

1. Migraines, seizures, epilepsy, multiple sclerosis, paralysis, stroke, Parkinson's, ALS (Lou Gehrig's), frequent and/or severe headaches, or any other neurological or central nervous system disorder or condition. <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Poor circulation, blood clot(s), varicose veins, blood/bleeding disorder, anemia, hemophilia, or any other blood/bleeding/circulatory disorder or condition. <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, confusion, memory loss, loss of consciousness, narcolepsy, Alzheimer's, dementia, or any other symptom(s) similar to the above. <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), chronic obstructed pulmonary disease (COPD), tuberculosis, emphysema, or any other respiratory disorder or condition. <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, rheumatic fever, or any other heart disorder or condition. <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Continued on next page</i>

<b>Section J – Health History</b> (continued)	
6. Disease, disorder or problem of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, sleep apnea or use of a sleep monitoring device. <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Female applicant(s) A. A breast disorder or condition, including but not limited to lump, cyst, fibrocystic breast disease, tumor, silicone injections. <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Disease, disorder or problem of the mouth/ gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ. <input type="checkbox"/> Yes <input type="checkbox"/> No	B. Pelvic pain, menstruation disorders, including but not limited to irregular periods or menstrual cycles, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages. <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis (Crohn's, ulcerative, etc.), recurrent or persistent diarrhea, recurrent vomiting, recurrent heartburn, stomach/abdominal pain, rectal problems, gastrointestinal bleeding, malabsorption syndrome, polyps, hemorrhoids, or any other digestive disorder or condition. <input type="checkbox"/> Yes <input type="checkbox"/> No	C. Abnormal pelvic exam/Pap smear, or HPV. <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Jaundice, unexplained weight loss or gain, pancreatitis, or any disease, disorder or condition of the gallbladder, spleen, pancreas, or liver. <input type="checkbox"/> Yes <input type="checkbox"/> No	D. Is any female applicant listed on this application currently pregnant or in the process of adoption or surrogate pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Kidney/bladder/urinary tract infection(s), stones, incontinence, blood in urine, or any other disease, condition or disorder of the kidneys or urinary system. <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Disease or problem of the eyes or sight, glaucoma, cataracts, detached retina, blurred vision or crossed eyes. <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, injury or disorder of back/spine/neck, sciatica, fracture, sprain/strain, fibromyalgia, arthritis, gout, carpal tunnel syndrome or any other musculoskeletal disorder. <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Disease or problem of the ears or hearing. <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Diabetes, pre-diabetes, high or low blood sugar, metabolic syndrome, elevated cholesterol, elevated triglycerides, thyroid, pituitary, adrenal, or any other metabolic or endocrine disorder or condition. <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Depression, anxiety, eating disorder, bipolar, chemical imbalance, attention deficit disorder (ADD or ADHD), autism spectrum disorder including Asperger's, schizophrenia, obsessive-compulsive, panic disorder, insomnia, received counseling/therapy, or any other behavioral or mental health issue. <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Immune disorder, lupus, scleroderma, mononucleosis, enlarged lymph nodes, chronic fatigue syndrome, or rheumatoid arthritis. <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Congenital condition or disorder such as congenital heart disease, cleft lip/palate, other birth defects, or developmental delay. <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Skin infection, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, shingles, scars/keloids, cosmetic or reconstructive surgery, or any other skin conditions. <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application whether or not evaluated by a health practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Sexually transmitted disease, such as herpes, genital warts, chlamydia, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other health practitioner for anything other than preventive care that has not been disclosed elsewhere on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Male applicant(s) A. A prostate condition, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, breast disorder or condition, including but not limited to enlarged breast, lump, cyst or cancer. <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Been hospitalized or treated in an urgent care clinic or emergency room for any conditions other than pregnancy? <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	25. Had a gastric bypass or lap-band surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
	26. Had an abnormal physical exam, laboratory results, X-ray, EKG, MRI, CT scan or been advised to undergo further testing, surgery, treatment or further consultation or evaluation with another healthcare practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>Continued on next page</i>

Section J – Health History (continued)	
<b>For questions 27–32, has any person listed on this application ever:</b>	<b>Other Health Questions:</b>
27. Had cancer, tumor/growth or leukemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	33. Has any applicant <b>ever</b> smoked or used any tobacco products such as: cigarettes, cigars, pipe, snuff or chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
28. Been in need of or a recipient of an organ or bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If cigarettes, please check the appropriate box based on the number of cigarettes smoked per day. If there are multiple applicants that smoke cigarettes, please respond based on the applicant that smokes the most number of cigarettes per day. <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50 or more
29. Been diagnosed as having hepatitis (A, B, C, D, E or any other type)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
30. 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	34. Have all applicants stopped using all tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No
31. Does anyone listed on this application have breast implants, eye/limb prosthesis, cochlear implant, hearing aid, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump, joint replacement, internal fixations (i.e. pins, plates, rods, etc.), neurostimulators, or any other prosthesis or implant (other than dental)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many months has it been since tobacco was last used? If multiple applicants have used tobacco and subsequently quit, please respond based on the applicant that most recently quit. <input type="checkbox"/> 0-6 <input type="checkbox"/> 6-12 <input type="checkbox"/> 12-24 <input type="checkbox"/> Greater than 24
32. Been diagnosed as having polio? <input type="checkbox"/> Yes <input type="checkbox"/> No	35. 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
	36. Has any applicant ever used any illegal or controlled I.V. drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	37. Has any applicant consumed any alcoholic beverages in the last six months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please check the appropriate box based on your average weekly consumption of alcoholic beverages within the past 6 months. One beverage equals 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor. If multiple applicants consume alcoholic beverages, please respond based on the applicant that consumes the most alcoholic beverages per week. <input type="checkbox"/> 0-3 <input type="checkbox"/> 4-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27 or more
	38. Has any applicant been advised to reduce alcohol intake, been in treatment for alcohol abuse or participated in AA within the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
	39. Has any applicant been prescribed or taken any medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Section J – Health History** (continued)

**Prescription Medications**

List all medications prescribed and/or taken within the last 12 months by any family member listed on this application (if not indicated in Step 2)

<b>Family Member</b>	<b>Medication/Dosage/Frequency</b> (i.e., Lopressor/100mg/daily)	<b>Illness for which Medication is Prescribed</b>	<b>Date Prescribed</b> (MM/DD/YY)	<b>Date Discontinued</b> (MM/DD/YY)	<b>Name, Phone No. of Physician or Hospital</b>
					Name: _____ Phone: _____
					Name: _____ Phone: _____
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					Name: _____ Phone: _____

**Section J – Health History** (continued)

**STEP 2: If you answered “YES” to any of the health history questions, give complete details (see the example below)**

Question Number of “YES”	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s)	Current Status
				Begin MM/YY	End MM/YY	Begin MM/YY	End MM/YY	Yes	No		
Example #17	Mary	Dr. John Doe 555-555-1000	Tonsillitis	Amoxicillin 250 mg. 4x day 08/02    09/02		08/02	09/02	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy 09/02	Good
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		

**Section J – Health History** (continued)

**Drilldown Health History Questions for Applicant**

Applicant Name	
Drilldown Question Number	
Drilldown Question Text	
Drilldown Question Answer	
Applicant Name	
Drilldown Question Number	
Drilldown Question Text	
Drilldown Question Answer	

**Drilldown Health History Questions for Spouse**

Spouse Name	
Drilldown Question Number	
Drilldown Question Text	
Drilldown Question Answer	
Spouse Name	
Drilldown Question Number	
Drilldown Question Text	
Drilldown Question Answer	

**Drilldown Health History Questions for Dependent(s)**

Dependent Name	
Drilldown Question Number	
Drilldown Question Text	
Drilldown Question Answer	
Dependent Name	
Drilldown Question Number	
Drilldown Question Text	
Drilldown Question Answer	

**Section K – Significant Terms, Conditions and Authorizations (TERMS)**

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 nonparticipating 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 N, 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 policies. Please note that surrendering your other coverage prior to approval of a UniCare policy could result in no coverage if the UniCare application is denied. NOTE: If you are adding a new dependent to an existing policy, the effective date will always be the first of the month following approval.

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.

<b>X</b>	_____
Initials of Applicant	Date

**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 policy.

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 policy is issued, separate annual family deductible and out-of-pocket maximums must be satisfied.

For purposes of the HSA-compatible plans, multiple policies 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 policy will be issued. I have discussed this option with my agent and understand that my premium amount, 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 policy effective dates.

<b>X</b>	_____
Initials of Applicant	Date

**Agreement (All applicants)**

I, the undersigned, agree to the following:

- I understand that it is mandatory and I promise to notify UniCare, in writing, immediately if I (the applicant) or any other person listed on this application receives medical treatment, advice, care or a diagnosis for anything other than preventive care after the date this application is signed but before the coverage effective date. UniCare has the right to review my application using the new information to determine whether to approve the application for coverage and, if approved, to determine the appropriate premium date.**
- I understand and agree to pay a separate non-refundable application fee of \$25 and the premium amount required with this application. Payment for the premium is a deposit which will be returned if my application is denied, or applied to the premium charges if my application is accepted.
- If my application for UniCare coverage is accepted as applied for, the coverage date will be as requested, but I agree I have no coverage under this application until I am notified in writing by UniCare that my application is approved.

*Continued on next page*

**Section K – Significant Terms, Conditions and Authorizations (TERMS)** (continued)

4. 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.
  5. **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.
  6. **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 Section J with them and (3) agree that all information contained in this application regarding them is complete and accurate.
  7. 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, and/or cashing of my check or charging my credit card by UniCare does not constitute approval of my application or create UniCare coverage.
  8. If I am accepted, this application will become part of the agreement between UniCare and myself.
  9. I certify that my employer will not, directly or indirectly, contribute to any premium payments for this policy, including through a health reimbursement arrangement (HRA) or Internal Revenue Code 125 Plan (cafeteria plan).
  10. UniCare may need to request additional medical information from my 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.
  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 on this application.
  13. My UniCare agent may receive copies of any correspondence about my medical history when correspondence is required.
- Some of the plans offered do not include all of the state-mandated health benefits. The Consumer Choice PPO Plans do not provide some of the state-mandated health benefits. State-mandated benefits not included are: 1) mental or nervous disorder including those with organic disease; 2) off-label drugs; 3) prescription contraceptive drugs and devices and related services; 4) telemedicine/telehealth; 5) acquired brain injury. In addition, coinsurance differentials between participating and nonparticipating providers may be greater than 30%. Purchase of this plan may limit your future coverage options in the event your health changes and needed benefits are not available under this plan. Coverage for pregnancy is not available under any UniCare Life & Health Insurance Company (UniCare) Individual and Family PPO Plan.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

<b>SIGN HERE</b>	Signature of Applicant* <b>X</b>	Date
	Signature of Spouse (if to be covered) <b>X</b>	Date
	Signature of Dependent Age 18 or Older (if to be covered) <b>X</b>	Date
	Signature of Dependent Age 18 or Older (if to be covered) <b>X</b>	Date

\*(or Custodial Parent's or Guardian's signature if applicant is under age 18)

### Section L – Agent Certification

**To be completed by your UniCare-Appointed Agent**

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

Did you see the applicant (and spouse, if applying) at the time this application was executed?  Yes  No

If no, please explain: \_\_\_\_\_

Does the applicant to be covered have any existing life insurance policies or annuity contracts?  Yes  No

By signing below, I verify that this application was completed by the applicant unless the Statement of Accountability (Section N) was completed.

Agent Signature <b>X</b>		Date	
Agent Name (please print)		Agent Email Address	
Agent No.	Agency No.	Agent Phone No.	Agent Fax No.

### Section M – Authorization for Use of Protected Health Information

**I authorize** that any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, the Medical Information Bureau, or other health care provider (“My Providers”) can release medical and insurance information and any other protected health information regarding health-related services and supplies provided to me, persons covered, or persons to be covered to 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, the Medical Information Bureau, or other health care provider to release and disclose entire medical records and health-related information 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 a period not longer than two (2) years 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 Significant Terms, Conditions and Authorizations (TERMS) (Section K). I understand that coverage is subject to the provisions in the Conditional Receipt. I have read and understand the above disclosure statement. I have read and understand this Application in its entirety. I have received a written plan description.

<b>SIGN HERE</b>	Printed Name of Applicant <b>X</b>	Signature of Applicant or Legal Representative	Date Signed
	Printed Name of Spouse <b>X</b>	Signature of Spouse or Legal Representative	Date Signed
	Printed Name of Dependent Age 18 or Older <b>X</b>	Signature of Dependent Age 18 or Older or Legal Representative	Date Signed
	Printed Name of Dependent Age 18 or Older <b>X</b>	Signature of Dependent Age 18 or Older or Legal Representative	Date Signed

If a legal representative signs on behalf of the applicant or spouse, a copy of the legal representative's authority must be attached to the application.

**Section N – 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
- Applicant is a child
- 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 "Significant Terms, Conditions, and Authorizations (TERMS) (Section K)."

Signature of Translator <b>X</b>	Today's Date (Required)
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**Conditional Receipt – To be completed by the agent and given to the applicant.**

Received from _____	
\$ _____ as a nonrefundable application fee payable to UniCare.	
\$ _____ as a premium, payable to UniCare.	
Subject to the following: <b>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.</b>	
<b>Dated this _____ day of _____, 20 _____.</b>	
Agent acknowledges receipt of money and delivery of Conditional Receipt.	
Signature of Agent <b>X</b>	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.