Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:
(must submit by mail if enclosing a check or money order)

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.342.1612

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

UNICARE®

INDIANA

INDIVIDUAL & FAMILY PPO HEALTH INSURANCE PLANS

UniCare Premier No Deductible Plan
UniCare 500, 1000, 1500, 2000, 3000, 5000 Plans
UniCare Saver Plan, UniCare High-Deductible (HSA Compatible) Plans

LIFE AND DENTAL PLANS APPLICATION

Thank you for applying with UniCare Life & Health Insurance Company (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 under this plan 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 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 by you.**
- Print clearly using blue or black ink (no correction fluid, please).
- This application must be received by UniCare Medical Underwriting within 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 choice of payment method to your agent, submit online OR mail to the address listed on this page.

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 1 month premium; complete the Monthly Bank Draft Authorization.
- **Quarterly billing:** Submit the 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; and
  - Physician address, phone number and fax numbers.
- 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 questions 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 Life & Health Insurance Company
Attn: UniCare Individual Services
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

UniCare Life & Health Insurance Company

Applicant's Social Security No.

INDIVIDUAL ENROLLMENT APPLICATION - INDIANA

- 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 ☐ Single ☐ 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 6 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 ☐ Caucasian	3 ☐ Black/African American	5a ☐ Native American Indian	A ☐ Amerasian	J ☐ Japanese	N ☐ Asian Indian	T ☐ Laotian
2 ☐ Hispanic	4 ☐ Asian	5b ☐ Alaskan Native	C ☐ Chinese	K ☐ Korean	P ☐ Hawaiian	V ☐ Vietnamese
		7 ☐ Filipino	H ☐ Cambodian	M ☐ Samoan	R ☐ Guamanian	Z ☐ Other

2. Choice of UniCare Individual Coverage

☐ Premier No Deductible Plan (G847)	☐ UniCare 2000 (G851)	☐ HSA Compatible Variable Deductible Plan (T780)	☐ High-Deductible Single $2,500 Plan (H004)
☐ UniCare 500 (G848)	☐ UniCare 3000 (PE32)	☐ HSA Compatible ($2,600/$5,200) Plan 2 (T086)	☐ High-Deductible Family $4,950 Plan (H005)
☐ UniCare 1000 (G849)	☐ UniCare 5000 (PE33)	☐ HSA Compatible ($5,000/$10,000) Plan 3 (T087)	☐ Life
☐ UniCare1500 (G850)	☐ UniCare Saver 2000 (G852)	☐ Other_____	☐ Dental

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 Height	MUST BE ACCURATE Weight	Date of Birth	Social Security No.	✓ Full Time Student	FamilyFlex® List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY WVR	UNICARE USE ONLY WVR
☐ Male ☐ Female	Yourself									
☐ Husband ☐ Wife	Spouse									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

FOR UNICARE USE ONLY – DO NOT WRITE BELOW

Group No.	Certificate No.	Agent I.D. No.	Effective Date	X Ref. Cert. No.	☐ AA ☐ AR
By	Date				

Applicant's Social Security No.

4. Other Coverage - Please answer **all** of the following questions.

A. Do you currently have, or has anyone to be insured had continuous coverage in the last 18 months? ☐ Yes ☐ No
Did this coverage end within the last 63 days for a reason other than fraud or non-payment of premium? ☐ Yes ☐ No

If Yes, please provide the following information:

Name of Insured(s)	Insurance carrier(s)	Effective date	End date

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

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

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.

Applicant's Social Security No. | | | | | | | | | |

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 28 **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) ☐ Yes ☐ No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy, or any similar symptoms ☐ Yes ☐ No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition ☐ Yes ☐ No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, or any other circulatory condition ☐ Yes ☐ 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 ☐ Yes ☐ No
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, or use of a sleep monitoring device ☐ Yes ☐ No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ ☐ Yes ☐ No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, or any other digestive disorder or condition ☐ Yes ☐ No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain, or hepatitis (indicate type:_____) ☐ Yes ☐ No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system ☐ Yes ☐ 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 ☐ Yes ☐ No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation, or prosthesis ☐ Yes ☐ No
13. Diabetes, thyroid, pituitary, adrenal, elevated cholesterol or any other metabolic endocrine disorders ☐ Yes ☐ No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome ☐ Yes ☐ No
15. Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? ☐ Yes ☐ 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 ☐ Yes ☐ No
17. Sexually transmitted disease, such as herpes, genital warts, etc. ☐ Yes ☐ No
18. Male applicant(s)
    a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, or implant ☐ Yes ☐ 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? ☐ Yes ☐ No
19. Female applicant(s)
    a) Breast disorder/cyst, lump, fibroid tumors, silicone injections, or implants ☐ Yes ☐ No
    b) Pelvic pain, menstruation disorders, abnormal pelvic exam/Pap smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages ☐ Yes ☐ No
    c) Date and result of last pelvic exam/Pap smear for each female over 16:
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ 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? ☐ Yes ☐ No
20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision ☐ Yes ☐ No
21. Diseases or problems of the ears or hearing, implant, or hearing aid ☐ Yes ☐ 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. ☐ Yes ☐ No
23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify:_____ ☐ Yes ☐ No
24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? ☐ Yes ☐ No
25. Had cancer, tumor/growth, leukemia, or cyst? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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)? ☐ Yes ☐ 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.

Applicant's Social Security No.

6B. Professional Services

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 ☐ Normal ☐ Abnormal	☐ 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 ☐ Normal ☐ Abnormal	☐ 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 ☐ Normal ☐ Abnormal	☐ 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

Question				
1. Has any applicant in the past 10 years smoked or used any tobacco products, such as: cigarettes, cigars, pipe, snuff, or chewing tobacco? ☐ Yes ☐ 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? ☐ Yes ☐ No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant in the past 10 years used any illegal or controlled I.V. drugs? ☐ Yes ☐ 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? ☐ Yes ☐ 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 ☐ day ☐ week ☐ month		Amount ________ per ☐ day ☐ week ☐ month	
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? ☐ Yes ☐ 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 lower 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 this application. 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 X_____

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 on the appropriate line following this section.

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 me.
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 that in considering my application, UniCare 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 *(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

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: ☐ 1 month ☐ 3 months		**Electronic Check Information** Select one: ☐ 1 month ☐ 3 months	
Credit Card: ☐ VISA ☐ 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.)

1. Submit the one month premium.
2. Complete section 8C, Monthly Checking Account Deduction Authorization.
3. Please choose the draft date in which you would like your premium debited from your checking account:
   ☐ 1st ☐ 8th ☐ 15th ☐ 22nd of each month.
4. 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

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

- 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 proposed subscriber (and spouse, if applying) at the time this application was executed? ☐ Yes ☐ No

If no, please explain:

_____

_____

- I verify that this application was completed by the applicant unless the Statement of Accountability (Section 11) was completed. ☐ Yes ☐ No

- Breakdown of premium collected:

Total Medical premium $ _____

Total Dental premium $ _____

Total Life premium $ _____

Total premium collected **$** _____

- Was the Monthly Checking Account Deduction Authorization (Section 8C) completed? *(only if applicable)*. ☐ Yes ☐ No
- Was a Conditional Receipt given? ☐ Yes ☐ No

Name of Writing Agent *(Print Name)*		Writing Agent's Street Address/Suite or Personal Mail Box No.	
William Stapleton		1000 Bridgeport Ave, 4th FL	
Agent/Agency I.D. No.	Sub-Agent I.D. No.	City/State/ZIP Code	Location No.
002252528		Shelton, CT 06484	
Phone No.	Fax No.	E-mail Address of Writing Agent	
(877) 567-5267	(888) 342-1612	bstapleton@healthplanone.com	
Signature of Writing Agent *(Required)*	Date *(Required)*	RSM Name	

Mail Plan to: ☐ **Agent** ☐ **Primary Applicant**
PLEASE NOTE: If neither box is checked, the Plan will be mailed directly to the primary applicant.

Mailing address:
Agent, please mail this application to:
UniCare
P.O. Box 5030
Bolingbrook, IL 60440-5030

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

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 _____ _____
Signature of Translator — Today's Date *(Required)*

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.