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®

MICHIGAN

INDIVIDUAL & FAMILY PPO HEALTH INSURANCE PLANS
UNICARE LIFE AND DENTAL PLANS APPLICATION

Thank you for applying with UniCare.

Please Note:

- Tobacco users and applicants with certain medical conditions pay an additional premium. For family applications, if any family member who is to be insured smokes or uses tobacco (or has used tobacco in the past 6 months), 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 7.
- **Coverage is not available if:**
  - any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
  - the applicant has not resided in the U.S. for the last six consecutive months.
- **Coverage is not guaranteed until approved in writing by UniCare. Do not cancel your current insurance coverage until you have been notified of approval by UniCare and your UniCare coverage is effective.**

Instructions

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

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

- For your own protection, **you, the applicant,** must complete this application. You are solely responsible for its accuracy and completeness.
- All information must be stated accurately.
- All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
- For additional information or explanations attach extra sheets, if necessary. **All attachments must be signed and dated.**
- Print clearly using blue or black ink (no correction fluid, please). **Sorry, but typed applications will not be accepted.**
- 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 your choice of payment method to your agent OR submit to the appropriate address listed below.

Billing Information

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

- **Monthly billing (with monthly bank draft authorization only):** Submit the one month premium, complete the Monthly Bank Draft Authorization.
- **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
  - Date of last pelvic examination
  - Results of last pelvic examination
  - Physician address, phone number and fax number
- Incomplete or illegible information such as the mailing address does not include city, state and ZIP code.
- ALL questions are not answered in Sections 4 and 6. If it does not apply to you, the answer should be "No." Do not leave any answers blank.
- The application is not signed and dated by the applicant and/or all dependents over age 18.
- Agent portion of application is not completed, signed, or dated with a date on or after applicant's signature date.
- Additional documentation or information is required.

Mailing Address

- **Applicant:** Please return this application to the agent.
- **Agent:** Please mail this application to the address below.
  UniCare Life & Health Insurance Company
  Attn: UniCare Individual Services - Michigan
  P.O. Box 5030
  Bolingbrook, IL 60440-5030

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

  Online application is also available at www.unicare.com

UNICARE.

UniCare Life & Health Insurance Company

Applicant's Social Security No.

INDIVIDUAL ENROLLMENT APPLICATION - MICHIGAN

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

1. Applicant Information (Please Print)

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

Reason for Application (Check one)

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

For Summary Bill (existing), I.D. No:

Mailing Address (If different from above) (P.O. Box or Personal Mail Box No.)		Home Phone No. ( )	Best Time To Call:
City	State ZIP Code	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 ( )	
E-mail Address (Optional)		If possible, do you want email notification? ☐ Yes ☐ No	

Have all applicants resided in the U.S. for the past six consecutive months? ☐ Yes ☐ No
If no, please provide name and explain:

Ethnic Code (Optional)

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

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				

2. Choice of UniCare Individual Coverage

- ☐ MI FIT 500 (DZ41) (Z815 eff. 7/1/08)
- ☐ MI FIT 1000 (DZ42) (Z816 eff. 7/1/08)
- ☐ MI FIT 1500 (DZ43) (Z817 eff. 7/1/08)
- ☐ MI FIT 2000 (DZ44) (Z818 eff. 7/1/08)
- ☐ MI FIT 3000 (DZ45) (Z819 eff. 7/1/08)
- ☐ MI FIT 5000 (DZ46) (Z820 eff. 7/1/08)
- ☐ UniCare Saver 2000 (X436) (Z810 eff. 7/1/08)
- ☐ UniCare Solaura℠ HSA Plan 1a* (DY82) (Z821 eff. 7/1/08)
- ☐ UniCare Solaura℠ HSA Plan 2a* (ED92) (Z822 eff. 7/1/08)
- ☐ UniCare Solaura℠ HIA Plus 1 (ED93) (Z825 eff. 7/1/08)
- ☐ UniCare Solaura℠ HIA Plus 2 (ED94) (Z826 eff. 7/1/08)
- ☐ UniCare Solaura℠ HIA Plus 3 (ED95) (Z827 eff. 7/1/08)
- ☐ UniCare Solaura℠ HIA 1 (ED96) (Z823 eff. 7/1/08)
- ☐ UniCare Solaura℠ HIA 2 (ED97) (Z824 eff. 7/1/08)
- ☐ UniCare High-Deductible Plan 1 – 80% (X437) (Z811 eff. 7/1/08)
- ☐ UniCare High-Deductible Health Plan 2* – 80% (X439) (Z812 eff. 7/1/08)
- ☐ UniCare High-Deductible Health Plan 3* – 100% (X440) (Z813 eff. 7/1/08)
- ☐ UniCare High-Deductible Health Plan 4 – 100% (X438) (Z814 eff. 7/1/08)
- ☐ Other_____
- ☐ Life
- ☐ Dental

* For UniCare HSA Plans, please complete the following:

☐ Yes, I do want to establish a Health Savings Account with UniCare's banking partner. Please forward my information to UniCare's banking partner. I understand that this includes my name, address, and social security number. (SSN required)

☐ No, I do not want to establish a Health Savings Account with UniCare's banking partner. Please do not forward my information to UniCare's banking partner.

3. Applicants for Coverage

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

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

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

Relation	Last Name First Name M.I.	MUST BE ACCURATE 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										
☐ Son ☐ Daughter										

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 coverage in the last 18 months? ☐ Yes ☐ No

If Yes, please provide the following information. List all carriers and use additional sheets if necessary.

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

Do you agree to discontinue your current coverage if this application is accepted? ☐ Yes ☐ No

If No, please explain:

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

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

If Yes, please provide the following information.

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

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

I certify that my UniCare group coverage will end/ended on (date):

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

If Yes, please provide the following information.

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

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

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

Eligible person(s)

F. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? ☐ Yes ☐ No

If Yes, please provide the following information.

Name of applicant	Effective date	End date

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

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis or any other neurological or central nervous system disorder(s) ☐ 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), chronic obstructed pulmonary disease (COPD), 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, including, but not limited to, irregular periods or menstrual cycles, 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

Has any person listed on this application **ever:**

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, treatment or further evaluation? ☐ Yes ☐ No
27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor or other person providing health care services for any other condition or symptom(s) (excluding childbirth), including wellness visits and routine exams, not listed on this application? ☐ Yes ☐ No
28. Been diagnosed as having or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)? ☐ 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 or prescribed within the last 12 months by any family member listed on this application.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued	Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/ZIP Code

6D. Other Health Questions

Question		1.		2.	
1. Has any applicant ever 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 ever 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? Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	☐ Yes ☐ No	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 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 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 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 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).

This 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 THE POLICY 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 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 High-Deductible 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 High-Deductible plan 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 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 policy 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 requested, 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 check or charging my credit card by UniCare does not constitute approval of my application or create UniCare coverage.
7. If I am accepted, this application will become part of the agreement between UniCare and myself.

8. I certify that my employer will not, directly or indirectly, contribute to any premium payments for this plan, including through a health reimbursement arrangement (HRA) or Internal Revenue Code 125 Plan (cafeteria plan).
9. UniCare may need to request additional medical information from your provider, and this may delay processing of this application. If the health care provider charges a fee for providing this information, UniCare will determine payment, and I will be responsible for any difference.
10. I understand that in considering my application, UniCare may use any information pertinent to this application, including medical conditions that occur after the signature date and before the original effective date.
11. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.
12. I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. UniCare may void all coverage for all persons listed on the application from the original effective date of the agreement for such material intentional misstatements or omissions. Any fraud or misstatements on the application may lead to rescission of the policy and, if applicable, possible disqualification of the HSA and adverse tax implications.

    If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided.
13. My UniCare agent may receive copies of any correspondence about my medical history when correspondence is required.

Authorization

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

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

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

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

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

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

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

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

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

Applicant's Social Security No.

8. Premium payment required with application. Please choose payment method from 8A.

Note: The premium amount may change during the Underwriting process as a result of being placed into a higher rating tier.

For Summary Bill, attach Summary Bill Forms.

8A. Please choose from the following options for initial and future payments.

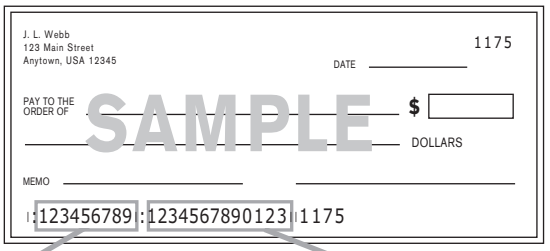
If you choose ongoing Quarterly Paper Billing, a $5 administrative fee applies to each paper bill.

- ☐ Initial and ongoing Monthly Checking Account Deduction (complete section 8B)
- ☐ Initial Credit Card payment (complete section 8C) and ongoing Monthly Checking Account Deduction (complete section 8B)
- ☐ Initial Credit Card payment (complete section 8C) and ongoing Quarterly Paper Bill
- ☐ Initial Electronic Check (complete section 8D) and ongoing Quarterly Paper Bill
- ☐ Initial Paper Check* and ongoing Monthly Checking Account Deduction (complete section 8B) **(This option isnot available when applying via the Internet)**
- ☐ Initial Paper Check* and ongoing Quarterly Paper Bill **(This option is not available when applying via the Internet)**

8B. Monthly Checking Account Deduction

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. Subsequent premium amounts will be debited from your checking account on the day you request below.

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 Routing and Account numbers here.

Bank Routing No.	Checking Account No.

Authorization:

As a convenience to me, I request and authorize UniCare Life & Health Insurance Company (UniCare) and/or its affiliates 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 understand that the initial payment amount may vary as a result of changes during underwriting and/or subsequent payment amounts may vary as a result of changes I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. I agree that UniCare's rights in respect to each such debit shall be the same as if it were a check 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 premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice.
I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit was 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 Checking Account Deduction and billed quarterly. **You will incur a $25 service charge for any withdrawal not honored.**

Applicant Name	Name of Bank or Financial Institution	
Authorized Signature (as it appears in the financial institution's records)	Name on Checking Account (PRINT)	Date

*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. Not available for applications submitted online. Please be aware that your check will not be returned to you. Business checks are not acceptable.

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

8C. One-Time Credit Card Payment

Credit Card: ☐ Visa ☐ MasterCard **Select One:** ☐ 1 month ☐ 3 months

Card No.: \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| (16 digits only)

Expiration Date: \| \| / \| \| Cardholder ZIP Code: \| \| \| \| \|

Authorized Signature (As it appears on the credit card)	PRINT Cardholder Name (As it appears on the credit card)	Date
X		

8D. Electronic Check

In lieu of sending a Paper Check, we can submit this 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 ☐ 3 months

Name on Checking Account (PRINT)	Bank Routing No.	Checking Account No.	Total Amount	Check No.
			$	

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 8B) completed? *(only if applicable)*. ☐ Yes ☐ No ▪ Was a Conditional Receipt given? ☐ Yes ☐ No

Name of Writing Agent (Print Name) William C. Stapleton		Name of Agency (Print name) HEALTH PLAN ONE	
Agent I.D. No. DCFPRSJSRZ	Sub-Agent I.D. No.	Agency I.D. No. LNGLQPNKLY	
Writing Agent's Street Address/Suite or Personal Mail Box No. 1000 Bridgeport Ave., 4th FL		Agency Address 1000 Bridgeport Ave., 4th FL	
City/State/ZIP Code Shelton, CT 06484	Location No.	Agency City/State/ZIP Code Shelton, CT 06484	
Phone No. (877) 567-5267	Fax No. (888) 342-1612	Agency Phone No. (877) 567-5267	Agency Fax No. (888) 342-1612
E-mail Address of Writing Agent sales@healthplanone.com		E-mail Address of Writing Agency sales@healthplanone.com	
Signature of Writing Agent (Required)	Date (Required)	Signature of Writing Agency	Date
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
233 S. Wacker Drive, Suite 3900, Chicago, IL 60606-6309

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.

Dated this _____ day of _____, 20 _____.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By X_____ _____

Signature of Agent | Agent I.D. Number

Notice of Information Practices

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

Notes