

# Individual & Family PPO Plans Application

UNICARE Performance  
UNICARE Performance Plus No Deductible  
UNICARE Saver 2000



Individual and Family  
Plans

**Thank you for applying with UNICARE.**

## PLEASE NOTE:

**Coverage is not available if:**

- any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
- the applicant has not resided in the U.S. for the last six (6) consecutive months.

**Coverage is not guaranteed until approved in writing by UNICARE.**

## 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 black ink. No correction fluid, please. **Sorry, but typed applications will not be accepted.**
- This application must be received by UNICARE Medical Underwriting within thirty (30) days from the signature date.
- UNICARE 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application is approved, any misstatements or omissions may result in future claims being denied and the plan being rescinded.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 Part 8 – Conditions of Application)**
- Please return this application and your check to your agent OR mail to the address shown below.

## Billing Information

**Carefully read the instructions accompanying each billing type and make sure that your check is attached to the application.**

- **Monthly billing (with monthly bank draft authorization only):** Submit the one (1)-month premium, complete the Monthly Bank Draft Authorization and attach a blank check marked “VOID” to the form.
- **Quarterly billing:** Submit the three (3)-month (quarterly) premium.

## Most common causes for delay in underwriting

- Missing, inaccurate or incomplete information such as:
  - Weight AND Height
  - Spouse’s social security number
  - Dependent’s social security number
  - Age AND 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 Section 4, 5, 6 and 7. 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 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 following address:

**UNICARE Life & Health Insurance Company**  
**Attn: Individual Services – Texas**  
**P.O. Box 5047**  
**Bolingbrook, IL 60440-5047**

New Applicant(s)     Add Dependent(s)

## 1. Choice of UNICARE Coverage – Choose one plan per application.

Please print in black ink.

**Plan Choice:**     UNICARE Performance:     \$600 Deductible     \$1,000 Deductible     \$1,500 Deductible     \$2,000 Deductible  
 UNICARE Performance Plus No Deductible:     \$30 Co-Pay  
 UNICARE Saver 2000:     \$2,000 Deductible

**Additional coverage:**     Term Life Insurance – Please include separate Life application addendum and additional premium with this application.  
 Dental Plan option

**Billing type:**     Monthly bank draft – One-month premium required. (Checking account deducted at the 1st of each month.)  
 Quarterly billing – Three-months premium required.  
 Summary Bill – Existing Summary No: \_\_\_\_\_ – Please attach Summary Bill cover sheet.

## 2. Applicant Information – Applicant must complete this application.

Height and weight must be stated accurately.

SEX	NAME: Last	First	M.I.	HEIGHT	WEIGHT	AGE	BIRTHDATE Month / Day / Year	SOCIAL SECURITY NO.	MARITAL STATUS	UNICARE USE ONLY			
										WVR	DUR	WVR	DUR
<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Married <input type="checkbox"/> Single				
RESIDENCE ADDRESS							BILLING ADDRESS						
Street Address							Street Address						
City / State / ZIP							City / State / ZIP						
Home Phone No. (    )			Business Phone No. (    )				In Care Of:						
Occupation			Name of Employer				Applicant/Spouse Maiden Name (If applicable)						

## 3. Spouse and Unmarried Applicants Applying for Coverage

Height and weight must be stated accurately.

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

RELATION	SEX	NAME: Last	First	M.I.	HEIGHT	WEIGHT	AGE	BIRTHDATE Month / Day / Year	SOCIAL SECURITY NO.	FULL-TIME STUDENT	UNICARE USE ONLY			
											WVR	DUR	WVR	DUR
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F													
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				

Have all listed applicants been residents of the U.S. for the last six (6) months? .....  Yes     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 past 18 months? .....  Yes     No  
**If yes**, provide Name of Insured: \_\_\_\_\_ Insurance Carrier(s): \_\_\_\_\_  
Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Please attach the Certificate of Creditable Coverage from your prior health insurance carrier.
- B. If you answered "yes" to A above, do you agree to discontinue your current coverage if this application is accepted? .....  Yes     No  
**If no**, explain: \_\_\_\_\_
- C. Has anyone on this application been insured by UNICARE in the last 5 years? .....  Yes     No  
**If yes**, name of former UNICARE Insured: \_\_\_\_\_ Plan / ID No: \_\_\_\_\_ Group No: \_\_\_\_\_  
UNICARE Plan: \_\_\_\_\_ City / State: \_\_\_\_\_ Date Cancelled: \_\_\_\_\_
- D. If you have UNICARE Group coverage (To be completed for each applicant) –  
I certify that my UNICARE Group Coverage terminated/will terminate 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.
- E. Has anyone identified on this application ever been declined, postponed, waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? .....  Yes     No  
**If yes**, provide name of applicant, insurance company name and a brief explanation: \_\_\_\_\_
- F. Are any persons applying for coverage on this application eligible for Medicare benefits? .....  Yes     No  
**If yes**, name of eligible person(s): \_\_\_\_\_
- G. 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**, name of applicant: \_\_\_\_\_ Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_



**5. Health History** (Continued) Use additional sheet if necessary.

QUEST. #	FAMILY MEMBER	CONDITIONS / TREATMENT MEDICATION(S) PRESCRIBED	DATE OF ONSET/ CHECK-UP OR SURGERY Mo / Yr	RECOVERY DATE Mo / Yr	DEGREE OF RECOVERY / RESULT OF EXAM	NAME, PHONE NO. & FAX NO. OF PHYSICIAN OR HOSPITAL ADDRESS / CITY / STATE / ZIP CODE

**B. Please provide information regarding the last doctor visit and/or physical examination for ALL family members you wish to cover.**

FAMILY MEMBER	DATE OF VISIT	REASON FOR VISIT	RESULTS		NAME, PHONE NO. & FAX NO. OF PHYSICIAN OR HOSPITAL ADDRESS / CITY / STATE / ZIP CODE
			Normal	Abnormal (Explain)	

**6. Medications** – List all **MEDICATIONS** taken currently or within the last 12 months by any family member listed on this application.

Use additional sheet if necessary.

FAMILY MEMBER	MEDICATION AND DOSAGE	ILLNESS FOR WHICH MEDICATION PRESCRIBED	DATE PRESCRIBED	DATE DISCONTINUED	NAME, PHONE NO. & FAX NO. OF PHYSICIAN OR HOSPITAL ADDRESS / CITY / STATE / ZIP CODE

**7. Lifestyle**

<p>1. Has any applicant ever smoked or used any tobacco products – such as: cigarettes, pipe, cigar, snuff, or chewing tobacco? <input type="checkbox"/> <b>Yes</b>     <input type="checkbox"/> <b>No</b></p>	<p>Family member(s): _____</p> <p>Amount per day: _____</p> <p>Type of product: _____</p> <p>Date discontinued: _____</p>	
<p>2. Has any applicant used illegal, controlled drugs, or substances in the last 10 years or been diagnosed as chemically or alcoholic dependent? <input type="checkbox"/> <b>Yes</b>     <input type="checkbox"/> <b>No</b></p>	<p>Family member(s): _____</p> <p>Type of product: _____</p> <p>Date ended: _____</p>	
<p>3. Has any proposed insured consumed alcoholic beverages in the last 6 months? <input type="checkbox"/> <b>Yes</b>     <input type="checkbox"/> <b>No</b> <i>Amount: A drink is 12 oz. of beer, or 6 oz. of wine, or 1 oz. of spirits.</i></p>	<p>Family member(s): _____</p> <p>Amount per day: _____</p> <p>Amount per week: _____</p> <p>Amount per month: _____</p> <p>Type of product: _____</p>	

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. No. of sheets attached

## 8. Conditions of Application

Applicant's Social Security No.

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

I, the undersigned, understand that, TX under the UNICARE plan for which I am applying, I will be entitled to lesser benefits if I use a non-participating Hospital, Physician, or other provider, than if I use a UNICARE 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 a statement of accountability 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 still like to request a specific effective date, we strongly recommend that you allow 60-75 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance, and will also prevent you from being required to pay for two policies.

**PLEASE NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.**

- I request that UNICARE assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.
- If UNICARE approves my application, please assign an effective date of  1st  15th of the month following approval.
- If UNICARE approves my application, please assign an effective date of  1st  15th of \_\_\_\_\_ . This 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, UNICARE WILL NOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES.**

### BILLING DATE

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

### AGREEMENT (All applicants)

I, the undersigned, agree to the following:

- I understand and agree to pay an application fee equal to the premium required with this application. This payment is only 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 specified above, but I agree I have no coverage under this application until I am notified in writing by UNICARE that I am accepted.
- I understand that UNICARE has the right to deny my application, and if it does so, I will be notified in writing and my application fees submitted will be returned.
- 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.
- DEPENDENTS AGE 18 AND OVER:** I represent that (1) my dependents age 18 and over 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 5, 6, and 7 with my dependents 18 and over, and (3) all information contained in this application regarding dependents age 18 and over is complete and accurate.

**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. Cashing of my check by UNICARE does not constitute approval of my application.**

- If I am accepted, this application will become part of the agreement between UNICARE and myself.
- UNICARE may request additional information, and this may delay processing of this application. If the health care provider bills for these services, UNICARE will determine payment, and I will be responsible for any difference.
- The selling agent has no authority to promise me coverage or to modify UNICARE underwriting policy or terms of any UNICARE coverage.**
- I alone am responsible for reading and accurately completing 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 on this application is eligible for benefits if any information on this application is false, incomplete or omitted. UNICARE may void all coverage from the original effective date of the agreement for such material misstatements or omissions.**

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. **If the responsible adult is not the natural parent, please submit court papers authorizing guardianship.**

**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 accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse.

- My UNICARE agent may receive copies of any correspondence about my medical history when correspondence is required.

(Continued on the following page)

### For UNICARE Use Only

GROUP NO.	CERTIFICATE NO.	AGENT TAX I.D. NO.	EFFECTIVE DATE	X REF. CERT. NO.	<input type="checkbox"/> AA <input type="checkbox"/> AR	BY	DATE
OCCUPATIONAL RIDER		APPLICANT		SPOUSE			
		<input type="checkbox"/> Approved <input type="checkbox"/> Does not meet criteria		<input type="checkbox"/> Approved <input type="checkbox"/> Does not meet criteria			

## 8. Conditions of Application *(Continued)*

### AUTHORIZATION

I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide UNICARE, its agents, or employees, including my UNICARE agent or broker, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury, or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below for a period not longer than two (2) years. A photocopy of this Authorization is as valid as the original. My authorized representative, UNICARE agent, or I am entitled to receive a copy of this form.

I have personally read and completed this application. I understand and agree to all the Conditions of Application and the Authorization (Part 8). I understand that coverage is subject to the provisions in the Conditional Receipt (Part 11). I understand that receipt of money with this application does not create UNICARE coverage. Coverage will come into effect only if this application is approved by UNICARE. I, the applicant, acknowledge that I have read and understand this Application in its entirety. I have received a written plan description.

### SIGNATURES *(Required)* – **IMPORTANT: All signatures MUST include today's date.**

Applicant / Parent or Legal Guardian <b>X</b>	Today's Date	Applicant's Spouse <i>(Required if applying for coverage)</i> <b>X</b>	Today's Date
Applicant's Dependent age 18 or over <b>X</b>	Today's Date	Applicant's Dependent age 18 or over <b>X</b>	Today's Date

## 9. To be completed by the UNICARE-Appointed Agent or Representative

### INSTRUCTIONS

**REMEMBER: Applications are not accepted if received after 30 days from signature date.**

- [REDACTED] If your client does not read or write English, the Exception to Standard Application form, Part C, must be completed.
- If a legal guardian is other than the natural parents, indicate relationship and submit copy of court-appointed guardianship papers.
- If an under-age family member does not reside with the applicant, the custodial parent must complete the Exceptions to Standard Application form, Part C. The proposed insured may sign for financial accountability.
- Please answer all questions below after the applicant has completed the application.
  1. 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**  
**If yes**, please indicate detailed information on a separate sheet of paper.
  2. Did you see the applicant (and spouse, if applying) at the time this application was executed? .....  **Yes**     **No**  
**If no**, please explain: \_\_\_\_\_
  3. Did the applicant personally complete the application? .....  **Yes**     **No**  
**If no**, an Exceptions to Standard Application form, Part C must be submitted with this application.
  4. Was a conditional receipt given? .....  **Yes**     **No**  
**Amount collected:** \$ \_\_\_\_\_
  5. Was the Monthly Bank Draft Authorization form completed? *(only if applicable)* .....  **Yes**     **No**

### Name of Regional Sales Manager

Name of Writing Agent <i>(Print name)</i>	Agent Tax I.D. No	Check one: <input type="checkbox"/> EIN <input type="checkbox"/> SS#	Phone No. (    )
Address	City / State / ZIP Code		Fax No. (    )
Signature of Writing Agent <i>(Required)</i> <b>X</b>			Date <i>(Required)</i>
<span style="background-color: black; color: black;">[REDACTED]</span>	Agent Tax I.D. No	Check one: <input type="checkbox"/> EIN <input type="checkbox"/> SS#	Phone No. (    )
Address	City / State / ZIP Code		Fax No. (    )
Signature of Sub-Agent <i>(Required)</i> <b>X</b>			Date <i>(Required)</i>

**Mail Plan to:**     Broker / Agent     Insured

**PLEASE NOTE: If neither box is checked, the Plan will be mailed directly to the insured.**



**Notice of Information Practices**

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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. For example, UNICARE may provide information to a hospital 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 correction 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.