Policy Store

Application Instructions For Unicare

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Policy Store for review along with the completed application. If you do not have access to a fax machine, send the completed application to Policy Store along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- ❏ Indicate your requested effective date.
- ❏ Select your preferred billing method.
- ❏ Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Unicare** if you are not paying by credit card.

Mail completed application and check to:

Policy Store
Attn: New Enrollment
105 West Main (Highway 276)
Quinlan, TX 75474

Policy Store will review your application for completeness and accuracy before we submit it to Unicare for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (866)526-9669 or e-mail us at jdcline@policystore.com.

Policy Store

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:

Policy Store
FAX# 888-277-5931

Dear Policy Store,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____after you have reviewed my application for completeness and accuracy.

☐ I will contact Policy Store at (866)526-9669 to verify receipt of my application.

**I understand that Policy Store will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend

I understand that the original signed application must still be mailed to Policy Store. I will mail the original signed application to :

Policy Store
Attn: New Enrollment
105 West Main (Highway 276)
Quinlan, TX 75474

I will send the original application as soon as I have been contacted by Policy Store with confirmation that my application has been received by fax and reviewed for completeness.

Signature: _____ Date: _____

UNICARE®

TEXAS

INDIVIDUAL & FAMILY PPO HEALTH INSURANCE PLANS

UniCare Performance Plans
UniCare Consumer Choice Plans
UniCare High-Deductible (HSA-Compatible) Plans

LIFE AND DENTAL PLANS APPLICATION

Thank you for applying with UniCare.

If you are electing a UniCare Consumer Choice PPO plan, please note: Some of the plans offered do not include all of the STATE-MANDATED HEALTH BENEFITS NORMALLY REQUIRED IN ACCIDENT AND SICKNESS INSURANCE POLICIES IN TEXAS. These standard health benefit plans may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose a standard health benefits plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in the policy.

– **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. 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 thirty (30) days from the signature date.

– UniCare Health and Dental Plans are available only in areas where the UniCare Network exists. Please see Provider Directories for more details.

– Even if this application is approved, any intentional misstatements or omissions may result in future claims being denied and the plan being rescinded.

– Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Section 7 – Conditions of Application).**

– Please return this application and your check to your agent OR mail to the address listed below.

– **Also please include a separate $25 nonrefundable application fee.** Only one application fee is required for families submitting more than one application at the same time in the same envelope. The application fee is waived for all applications submitted online.

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.

– **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
  - 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.

– Failure to include a **separate** $25 nonrefundable application fee check.

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: Individual Services - Texas
P.O. Box 5030
Bolingbrook, IL 60440-5030

UNICARE

UniCare Life & Health Insurance Company

Applicant's Social Security No.

INDIVIDUAL ENROLLMENT APPLICATION - TEXAS

– 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 than 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: | 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.)

Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? ☐ Yes ☐ No
If yes, please provide name and explain:

Language preference (Optional) ☐ English ☐ Spanish ☐ Korean ☐ Chinese ☐ Polish ☐ Other (Specify):

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

2. Choice of UniCare Individual Coverage

☐ Saver 2000 (G859)
☐ Performance 5000 (PE29)
☐ Performance 3000 (PE28)
☐ Performance 2000 (G858)
☐ Performance 1500 (G857)
☐ Performance 1000 (G856)
☐ Performance 600 (G855)
☐ Performance 500 (G854)
☐ Performance Plus No Deductible (G853)
☐ Consumer Choice $5000 (R414)
☐ Consumer Choice $2000 (R413)
☐ Consumer Choice $1000 (R412)
☐ Life
☐ Dental
☐ HSA-Compatible Variable-Deductible Plan (T778)
☐ HSA-Compatible ($2,600/$5,200) Plan 2 (T766)
☐ HSA-Compatible ($5,000/$10,000) Plan 3 (T767)
☐ High-Deductible Single $2,500 Plan (H033)
☐ High-Deductible Family $4,950 Plan (H034)

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	Weight	Date of Birth	Social Security No.	FamilyFlex List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY WVR	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 coverage in the last 18 months? ☐ Yes ☐ No

If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

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
3. 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.

I have discussed Life Insurance with my agent and decline to apply – Initial: _____

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 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), 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 or any other 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

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 or treatment? ☐ 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) 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.

6B. Professional Services

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Applicant's Social Security No.

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

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? ☐ 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 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.

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 the

☐ 1st of the month following approval.
☐ 15th of the month following approval.
☐ 1st of _____ ☐ 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, ONLY UNICARE CAN CHANGE THIS DATE, HOWEVER, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE PLAN IS ISSUED.
Initial X _____

Billing Date

UniCare premiums are due on the 1st of each month. Insureds with a mid-month premium 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:

1. I understand and agree to pay a non-refundable application fee of $25 to be paid on a separate check or through a separate credit card deduction and to pay the premium amount required with this application. If my application is denied, UniCare will return only the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.
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 I submitted will be returned.
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) 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, and/or cashing of my nonrefundable application fee check or cashing of my premium check or charging either of these amounts to 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. UniCare may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, UniCare will determine payment, and I will be responsible for any difference.
9. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.
10. 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 from the original effective date of the agreement for such material intentional 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.

    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. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.
11. My UniCare agent may receive copies of any correspondence about my medical history when correspondence is required.

Authorization / Disclosure Statement

Some of the plans offered do not include all of the state-mandated health benefits. The Consumer Choice PPO Plans do not provide some of the state-mandated health benefits. State-mandated benefits not included are: 1) mental or nervous disorders including those with organic disease; 2) off-label drugs; 3) prescription contraceptive drugs and devices and related services; 4) telemedicine/telehealth. In addition, coinsurance differentials between participating and nonparticipating providers may be greater than 30%. Purchase of this plan may limit your future coverage options in the event your health changes and needed benefits are not available under this plan. Coverage for pregnancy is not available under any UniCare Individual and Family PPO Plan.

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, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UniCare.

This authorization shall remain in force for a period not longer than 2 years following the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or any of my dependents who are also applying for coverage or to the extent that UniCare has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by UniCare except as authorized by me or as required by law.

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

I understand and agree to all the 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 the above disclosure statement. I have read and understand this Application in its entirety. I have received a written plan description.

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

ATTACH INITIAL PREMIUM CHECK AND SEPARATE CHECK FOR APPLICATION FEE HERE. DO NOT TAPE.

Applicant's Social Security No.

8. Payment Method – Submit nonrefundable application fee and premium payment with application (required).

8A. Nonrefundable $25 Application Fee Payment

Only one application fee is required for families submitting more than one application at the same time. No application fee is required for applications submitted online.

☐ Please charge the separate, nonrefundable application fee to my credit card. ☐ I am attaching a separate check for the non-refundable application fee.

Initial Premium Payment by Credit Card

New members only. Not available to make a coverage change.

Select one:	Initial Premium Amount	Credit Card:	Credit Card No.	Expiration Date
☐ 1 month ☐ 3 months	$	☐ VISA ☐ MasterCard		
Cardholder's Name		**Cardholder's ZIP Code**	**Authorized Signature** (as it appears on the credit card) X	**Today's Date**

8B. Payment Type (First payment will be credited to approved applicants only.)

☐ **Monthly Billing** (Available with Monthly Checking Account Deduction).
- Submit the one (1) month premium.
- Complete section 8C, **Monthly Checking Account Deduction Authorization.**
- If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account on the first of the month ONLY.

☐ **Quarterly Billing**
- Submit the three (3)-month premium.

8C. Monthly Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated. If the account listed below is a joint account, both account holders' signatures are required. **UniCare must be notified of any changes to your bank account no later than the 20th of the month preceding the change.**

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.

Applicant Name	Applicant Social Security No.	Name on Checking Account		
Name of Bank or Financial Institution	Address	City	State	ZIP Code
Checking Account No.	Bank Routing No.	Federal Credit Union Routing No.		
Authorized Signature (as it appears in the financial institution's records)	Date	Authorized Signature (as it appears in the financial institution's records)	Date	

(Continued on next page)

DO NOT WRITE BELOW

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 funds collected:

Total Medical premium . . . . . $ .....

Total Dental premium. . . . . $ .....

Total Life premium . . . . . $ .....

Nonrefundable application fee . . . . . $ $25

Total funds 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.	
Jeffrey Cline		105 West Main (Highway 276), Quinlan, TX 75474	
Agent/Agency I.D. No.	**Sub-Agent I.D. No.**	City/State/ZIP Code	Location No.
BNKPKNLLNZ		Quinlan, TX 75474	
Phone No.	Fax No.	E-mail Address of Writing Agent	
(866) 526-9669	(888) 277-5931	jdcline@policystore.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**

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 nonrefundable application fee payable to UniCare;
$_____ as a premium, payable to UniCare.

Subject to the following:

IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE PREMIUM SUBMITTED WITH THIS APPLICATION IF THIS 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.

Dated this _____ day of _____ , 20 _____.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By X _____ _____
TXIMFAPLCR0903 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. 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.

UNICARE®

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

APPLICANT'S SOCIAL SECURITY NO.

APPLICANT NAME	POLICY NO.

PLEASE NOTE:

This form must be completed, signed and submitted to UNICARE along with your completed application. Please keep the second copy of this "Notice" for your files.

Will this insurance replace any other accident and sickness insurance presently in force? ..... ☐ Yes ☐ No

If yes, please supply the name of the other carrier: _____
and read the following information and sign below.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by UNICARE. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on _____
Date

X _____
Signature of Applicant

UNICARE Life & Health Insurance Company

FOR CONSUMER CHOICE PLANS ONLY

A healthy dose of innovation℠

TEXAS DEPARTMENT OF INSURANCE
REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL INDEMNITY CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

AS REQUIRE BY 28 TAC §21.3542, I have been offered the opportunity to apply for an accident and sickness insurance policy or evidence of coverage in the same category that most closely approximates the Consumer Choice Health Benefit Plan, that includes state-mandated health benefits, and that is otherwise authorized by the Insurance Code.

As required by 28 TAC §21.3530, I have been informed that the UNICARE Life & Health Consumer Choice Health Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
Mental or Nervous Disorders including those with organic disease		X
Off-label drugs		X
Oral contraceptives		X
Prescription contraceptive drugs and devices and related services		X
Telemedicine/Telehealth		X
Coinsurance differential between participating and nonparticipating providers may be greater than 30%	X	

I also understand that if I purchase a health plan that excludes or reduces coverage for a certain condition, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI Web site at www.tdi.state.tx.us/consumer/indexc.html, or by calling 1-800-252-3439.

_____

Signature of Applicant

_____

Name of Applicant

_____

Address

_____

City State Zip

_____

Date

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed and submitted annually.

UNICARE®

Authorization

Health plan administered or insured by any of the following: UNICARE Life & Health Insurance Company, UNICARE Health Insurance Company of the Midwest (IN and IL), UNICARE Health Plans of the Midwest, Inc. (HMO in IN and IL only) or UNICARE Health Insurance Company of Texas (TX only), UNICARE Health Plans of Texas, Inc. (HMO in TX only), UNICARE Health Plans of Virginia, Inc. (HMO in VA only) or UNICARE Health Plan of Oklahoma, Inc. (HMO in OK only).

Section A: Individual authorizing use and/or disclosure.

Name				Phone No.
Address	City	State	ZIP Code	Member Identification No.

Section B: The use and/or disclosure being authorized.

PHI to Be Used and/or Disclosed: **{Specifically describe the PHI to be used and/or disclosed}**

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information (PHI).

Entities or Persons Authorized to Use or Disclose: **{Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above}**

Entities or Persons Authorized to Receive: **{Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above}**

Purpose of this Authorization: ☐ At request of individual. ☐ For the following purposes:

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

Section C: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office	Phone No.	Fax No.	Address

Individual's Signature

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name	Signature	Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name	Signature	Relationship to Individual	Date

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

UNICARE

Conditioned Authorization to Use or Disclose for Enrollment or Eligibility

UNICARE Life & Health Insurance Company, UNICARE Health Insurance Company of the Midwest, UNICARE Health Plans of the Midwest, Inc.

Section A: The Individual.

Name				Phone No.
Address	City	State	ZIP Code	Member Identification No.

Section B: The use and/or disclosure being authorized.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to UNICARE. 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 my signature below, I acknowledge that any agreements I have made to restrict my protected health information do 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 my entire medical record 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, 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 (30 months in IL, NV and VA) months following the date of my 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 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 {the recipient} 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 my complete medical record, 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 or I will receive a copy of this authorization upon request.

Contact Office	Phone No.	Fax No.	Address

Individual's Signature

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name	Signature	Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name	Signature	Relationship to Individual	Date

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.