

Wait!

**Please call before
attempting to complete your application!**

Avoid headaches and delays by allowing our office to assist you. We can help you complete your application and answer any questions you may have. You'll be surprised at how simple completing an application can be.

1 800 721-2618

(6:30 a.m. to 6:30 p.m. PST. Monday through Friday)

Please mail your application to:

Health One Insurance Agency
1344 Disc Dr. #210
Sparks, NV 89436
Attn: APDT



A healthy dose of innovation.™

Indiana

Individual & Family PPO Health Insurance Plans

UNICARE Premier No Deductible Plan
UNICARE 500, 1000, 1500, 2000, 3000, 5000 Plans
UNICARE Saver Plan
UNICARE High-Deductible (HSA-Compatible) Plans
UNICARE Life and Dental Plans

Application

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. 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application is approved, any misstatements or omissions may result in future claims being denied and the plan being rescinded.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 at right.

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.

Mailing Address

- **Applicant:** Please return this application to the agent.
- **Agent:** Please mail this application to the address below.

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



Applicant's Social Security No.									

A healthy dose of innovation:

Individual Enrollment Application - Indiana

UNICARE Life & Health Insurance Company

- 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. ()
In care of:		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Spouse's Social Security No. (Required)
Billing Type:	<input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Quarterly Billing <input type="checkbox"/> Summary Bill (Please attach Summary Bill cover sheet.)	Maiden Name of Applicant/Spouse (If applicable)	
Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide name and explain:			
Language preference (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Polish <input type="checkbox"/> Other (Specify):			
Ethnic Code (Optional)			
1 <input type="checkbox"/> Caucasian	3 <input type="checkbox"/> Black/African American	5a <input type="checkbox"/> Native American Indian	A <input type="checkbox"/> Amerasian
2 <input type="checkbox"/> Hispanic	4 <input type="checkbox"/> Asian	5b <input type="checkbox"/> Alaskan Native	C <input type="checkbox"/> Chinese
		7 <input type="checkbox"/> Filipino	H <input type="checkbox"/> Cambodian
			J <input type="checkbox"/> Japanese
			K <input type="checkbox"/> Korean
			M <input type="checkbox"/> Samoan
			N <input type="checkbox"/> Asian Indian
			P <input type="checkbox"/> Hawaiian
			R <input type="checkbox"/> Guamanian
			T <input type="checkbox"/> Laotian
			V <input type="checkbox"/> Vietnamese
			Z <input type="checkbox"/> Other

2. Choice of UNICARE Individual Coverage

Plan Choice:	<input type="checkbox"/> UNICARE Saver 2000 (G852)	<input type="checkbox"/> UNICARE 2000 (G851)	<input type="checkbox"/> UNICARE 500 (G848)
<input type="checkbox"/> HSA-Compatible Plan 1 (T085)	<input type="checkbox"/> UNICARE 5000 (PE33)	<input type="checkbox"/> UNICARE 1500 (G850)	<input type="checkbox"/> Premier No Deductible Plan (G847)
<input type="checkbox"/> HSA-Compatible Plan 2 (T086)	<input type="checkbox"/> UNICARE 3000 (PE32)	<input type="checkbox"/> UNICARE 1000 (G849)	<input type="checkbox"/> Life
<input type="checkbox"/> HSA-Compatible Plan 3 (T087)			<input type="checkbox"/> Dental

3. Applicants for Coverage

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

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

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

Relation	Last Name	First Name	M.I.	MUST BE ACCURATE		Date of Birth	Social Security No.	✓ Full Time Student	FamilyFlex List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY	
				Height	Weight						WVR	WVR
<input type="checkbox"/> Male <input type="checkbox"/> Female	Yourself											
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse											
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												

FOR UNICARE USE ONLY - DO NOT WRITE BELOW

Group No.	Certificate No.	Agent I.D. No.	Effective Date	X Ref. Cert. No.	<input type="checkbox"/> AA <input type="checkbox"/> AR
By	Date				

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

A. Do you currently have, or has anyone to be insured had continuous coverage in the last 18 months? Yes No
 If Yes, please provide the following information:

Name of insured(s)	Insurance carrier(s)	Effective date	End date
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Do you agree to discontinue your current coverage if this application is accepted? Yes No
If No, please explain:

B. Has anyone on this application been insured by UNICARE in the last 5 years? Yes No
If Yes, please provide the following information.

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

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

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

I do not wish to enroll in any available Conversion Agreement. I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.

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

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

E. Are any persons applying for coverage on this application eligible for Medicare benefits? Yes No
If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.

Eligible person(s)

F. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? Yes No
If Yes, please provide the following information.

Name of applicant	Effective date	End date
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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: _____

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 recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 28 **within the last 10 years:**

<p>1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis, or any other neurological or central nervous system disorder(s) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>18. Male applicant(s)</p> <p>a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, or implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy, or any similar symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>19. Female applicant(s)</p> <p>a) Breast disorder/cyst, lump, fibroid tumors, silicone injections, or implants <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Date and result of last pelvic exam/Pap smear for each female over 16:</p> <p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, or any other circulatory condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>21. Diseases or problems of the ears or hearing, implant, or hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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 <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, or use of a sleep monitoring device <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, or any other digestive disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>25. Had cancer, tumor/growth, leukemia, or cyst? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain, or hepatitis (indicate type: _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery, or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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 <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>28. Been diagnosed or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation, or prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>13. Diabetes, thyroid, pituitary, adrenal, or any other endocrine disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>15. Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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 <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>17. Sexually transmitted disease, such as herpes, genital warts, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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

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

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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> 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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> 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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> 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 in the past 10 years smoked or used any tobacco products, such as: cigarettes, cigars, pipe, snuff, or chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant in the past 10 years used any illegal or controlled I.V. drugs? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.</i>	1. Family member		2. Family member	
	Amount	_____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	Amount	_____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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 non-participating hospital, physician, or other provider, than if I use a UNICARE independently contracted participating hospital, physician, or other provider.

All applicants age 18 and over must personally read, agree to, and sign 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, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE CERTIFICATE OF COVERAGE 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 the premium required with this application. This payment is a deposit which will be returned if my application is denied, or applied to the premium charges if my application is accepted.

2. If my application for UNICARE coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by UNICARE that my application is approved.
3. I understand that UNICARE has the right to deny my application, and if it does so, I will be notified in writing and the premium 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, 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. 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 misstatements or omissions.
If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided.
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

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 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.

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

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse (<i>required if applying for coverage</i>)	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 HERE.
DO NOT TAPE.**

Applicant's Social Security No.									

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

8A. Initial Premium Payment by Credit Card			8B. Payment Type		
New members only. Not available to make a coverage change.			<input type="checkbox"/> Monthly Billing (Available with Monthly Checking Account Deduction).		
Select one:	<input type="checkbox"/> 1 month	<input type="checkbox"/> 3 months	Initial Premium Amount	1. Submit the one (1) month premium.	
			\$	2. Complete section 8C, Monthly Checking Account Deduction Authorization.	
Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard			3. 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.		
Credit Card No.		Expiration Date			
Cardholder's Name		Cardholder's ZIP Code			
Authorized Signature (as it appears on the credit card)		Today's Date			
X					
			<input type="checkbox"/> Quarterly Billing – Submit the three (3)-month premium.		
Please note: First payment will be credited to approved applicants only.					

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.

You will incur a \$25 service charge for any withdrawal not honored.

Applicant Name	Applicant Social Security No.	Name on Checking Account			
Name of Bank or Financial Institution	Address	City	State	ZIP Code	
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 reverse)

DO NOT WRITE BELOW

