UNICARE

2-50 Small Group Employee Application

Medical, Dental Coverage & Life Insurance underwritten by UNICARE Life & Health Insurance Company.

INSTRUCTIONS

1. You, the employee, must complete this application in your own handwriting. You are solely responsible for its accuracy and completeness.	2. All questions must be answered in full or the application may be returned to you resulting in a delay in processing.	3. Print clearly using black ink. Typed applications will not be accepted.

UNICARE GROUP NUMBER
(If existing UNICARE Group)

1. COVERAGE

A. MEDICAL COVERAGE SELECTION - Check only one.

High Options	Medium Options	Low Options
☐ UNICARE Premier 500	☐ UNICARE Premier 1000	☐ UNICARE 1000
	☐ UNICARE 500	☐ UNICARE 2000
		☐ UNICARE Saver 1000

B. DENTAL COVERAGE SELECTION - Check only one.

High Options	Medium Options	Low Options	Voluntary Options
☐ High Option PPO	☐ Standard PPO	☐ Basic PPO	☐ UNICARE VB
☐ GoldPremium	☐ GoldPlus	☐ SilverStandard	☐ UNICARE VS
	☐ GoldStandard	☐ SilverSaver	

C. OPTIONAL DEPENDENT LIFE INSURANCE ☐ Yes ☐ No *Available only if offered by employer.*

2. EMPLOYEE INFORMATION – *Must be completed by employee.*

☐ New group enrollment ☐ Late enrollment ☐ New hire ☐ COBRA effective date: ___/___/___
☐ Family addition ☐ Re-enrollment ☐ Change of coverage ☐ Open Enrollment

LAST NAME	FIRST NAME	M.I.	MARITAL STATUS ☐ Single ☐ Married	SOCIAL SECURITY NO.

HOME ADDRESS (P.O. Box not acceptable unless rural P.O. Box)	CITY	STATE	ZIP CODE

HOME PHONE NO.	APPLICANT'S/SPOUSE'S MAIDEN NAME
( )	

EMPLOYER NAME	OCCUPATION / JOB TITLE	FULL-TIME DATE OF HIRE	SPOUSE'S SOCIAL SECURITY NO.

BUSINESS PHONE NO.	SALARY	☐ Hourly ☐ Weekly ☐ Monthly	LIFE INSURANCE BENEFICIARY Last Name, First Name, Middle Initial	RELATIONSHIP	AGE
( )	$				

3. EMPLOYEE / DEPENDENT INFORMATION – *List yourself and only those eligible dependents who are applying for coverage.*

An eligible "dependent" is an employee's lawful spouse; unmarried children, or step-children of the employee who are under age 19; unmarried children of the employee from their 19th to their 23rd birthday who are full-time students.

If spouse's last name is different from yours, please explain. _____

If family addition is spouse, date of marriage: ___/___/___

Please don't forget height and weight.

SEX	LAST NAME	FIRST NAME	M.I.	HEIGHT	WEIGHT	DISABLED?	BIRTHDATE Month Day Year	UNICARE USE ONLY Creditable Coverage
10 ☐ Male 20 ☐ Female	Employee					☐ Yes ☐ No		
30 ☐ Male 40 ☐ Female	Spouse					☐ Yes ☐ No		
50 ☐ Male 70 ☐ Female	Relationship: _____					☐ Yes ☐ No		
51 ☐ Male 71 ☐ Female	Relationship: _____					☐ Yes ☐ No		
52 ☐ Male 72 ☐ Female	Relationship: _____					☐ Yes ☐ No		

4. COVERAGE DECLINATION – *To be completed if any coverage is declined or refused by an eligible employee and/or their eligible family members.*

A. Medical Coverage declined: ☐ Myself ☐ Spouse ☐ Children ☐ Spouse and Children

Reason for declining coverage: *(Check one)*

☐ Covered by spouse's group coverage – Carrier name and I.D. Number: _____

☐ Covered by UNICARE Individual Policy

☐ Enrolled in any other Insurance Carrier Plans – Carrier name: _____

☐ Spouse covered by employer's group medical coverage

☐ Medicare

☐ Covered by TRICARE or Champva

☐ Other (Explain): _____

B. Dental Coverage declined for:

☐ Myself
☐ Spouse
☐ Children
☐ Spouse and Children

C. Life Insurance declined for:

☐ Myself ☐ Dependent(s)

I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily and no one has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY NOT BE ELIGIBLE FOR COVERAGE IN THIS PLAN UNTIL THE GROUP'S ANNIVERSARY DATE SHOULD WE APPLY AT A LATER DATE. I ALSO UNDERSTAND THAT IF MY DEPENDENTS AND I APPLY FOR COVERAGE AT A LATER DATE, ANY PRE-EXISTING CONDITIONS MAY NOT BE COVERED FOR 12 MONTHS FROM THE EFFECTIVE DATE OF COVERAGE.*

X _____ _____

Signature if declining coverage for employee/dependent(s) ***Date (Month / Day / Year)***

* If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

5. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 2 to 14 EMPLOYEES AND LATE ENROLLEES

(Include information on all family members you wish to cover.)

All questions must be answered "yes" or "no." INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

	Yes	No
1. Within the last 10 years, has any person listed on this application had a clear distinct symptom that would cause an ordinarily prudent person to seek advice, diagnosis or treatment for, or had treatment recommended for, received advice for, received treatment (including medication) for, or been hospitalized for any of the following conditions?		
a. Heart attack, heart murmur, disorder of the heart, stroke, chest pain, high blood pressure, anemia, varicose veins, or any disorder of the blood, blood vessels, hyperlipemia or arteriosclerosis	☐	☐
b. Ulcer, colitis, gallstone, hernia, or any other disorder of the stomach, intestines, rectum, gall bladder, or liver	☐	☐
c. Cancer, cyst, tumor, or growth	☐	☐
d. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, urinary system, or male or female organs	☐	☐
e. Tuberculosis, asthma, hay fever, adenoids, pleurisy, or any other disorder of the lungs or respiratory system	☐	☐
f. Epilepsy, fainting spells, mental or nervous condition, paralysis, or any disorder of the brain or nervous system	☐	☐
If epileptic, date of last seizure: ______________________		
g. Arthritis, rheumatic fever, back trouble, TMJ, or any other disorder of the joints, muscles, or bones	☐	☐
h. Any physical deformity or defect, serious bodily injury, fracture, concussion, burn and/or congenital problems, or any cosmetic surgery	☐	☐
i. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same	☐	☐
2. Within the last 10 years, has any person listed on this application:		
a. Had any surgery, been advised to have surgery, or been confined to a hospital?	☐	☐
b. Been medically diagnosed with an immune deficiency disorder, AIDS, or AIDS related complex, or been diagnosed as HIV positive?	☐	☐
3. Is any person listed on this application:		
a. Currently under treatment, receiving counseling or taking medicine for any condition or disease?	☐	☐
b. Currently pregnant or is any male expecting a child with anyone, whether listed on this application or not?	☐	☐
If yes, due date (Month, Day, Year) ______________________ Any history of complication of pregnancy?	☐	☐
c. A user of tobacco products within the last 2 years?	☐	☐

5A. IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING:

Please explain and provide us with **FULL DETAILS** for each "Yes" answer to any condition(s) checked in all the preceding boxes.
(Attach additional sheets, if necessary.)

QUESTION # / NAME OF FAMILY MEMBER (As identified on Physician's Record)		NAME OF HOSPITAL, CLINIC, AND/OR PERSON PROVIDING CARE	PHONE NO. ( )
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED ☐ Still under treatment	ADDRESS	SUITE NO.
NAME OF CONDITION/ILLNESS		CITY / STATE / ZIP CODE	FAX NO. ( )
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS		MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE	
QUESTION # / NAME OF FAMILY MEMBER (As identified on Physician's Record)		NAME OF HOSPITAL, CLINIC, AND/OR PERSON PROVIDING CARE	PHONE NO. ( )
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED ☐ Still under treatment	ADDRESS	SUITE NO.
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NAME OF CONDITION/ILLNESS		CITY / STATE / ZIP CODE	FAX NO. ( )
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS		MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE	

6. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 15-50 EMPLOYEES:

	Yes	No
1. Within the last 10 years, has any person listed on this application had a clear distinct symptom that would cause an ordinarily prudent person to seek advice, diagnosis or treatment for, or had treatment recommended for, received advice for, received treatment (including medication) for, or been hospitalized for any of the following conditions?		
Cardiovascular disease or heart disorders; stroke; disorders of the kidney, stomach, intestines or liver; mental or nervous conditions; central nervous system disorders; diabetes; any disorders of the lungs or respiratory system; cancer or immune deficiency disorders, AIDS, or AIDS-related complex?	☐	☐
2. During the last 24 months, has any person listed on this application had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than $5,000?	☐	☐
3. Is any person listed on this application:		
a. Currently under treatment, receiving counseling or taking medicine for any condition or disease?	☐	☐
b. Currently pregnant, or is any male expecting a child with anyone, whether listed on this application or not?	☐	☐
If yes, due date (Month, Day, Year) _____		
c. A user of tobacco products within the last 2 years?	☐	☐

If you answer "Yes" to any of the above questions, complete the following: *(Attach additional sheets, if necessary.)*

Name of patient: _____

Condition/Illness: _____

Dates of treatment: From _____ Through _____

Treatment rendered: _____

Still under treatment? ☐ Yes ☐ No

Medication and dosage taken: _____

Date: From _____ Through _____

Treatment provider's name/address: _____

_____

Name of patient: _____

Condition/Illness: _____

Dates of treatment: From _____ Through _____

Treatment Rendered: _____

Still under treatment? ☐ Yes ☐ No

Medication and dosage taken: _____

Date: From _____ Through _____

Treatment provider's name/address: _____

_____

7. OTHER MEDICAL COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS *(All questions must be answered.)*

	Yes	No
1. Do any persons on this application intend to continue other Group coverage if this application is accepted?	☐	☐
If yes, name of person: _____		
Insurance Co. _____ Policy No. _____		
2. Does any person applying for coverage currently have health insurance coverage? If yes, Proof of Coverage must be submitted. *(See below.)*	☐	☐
Has any person applying for coverage had health insurance coverage at any time in the past twelve (12) months? *(Any Individual UNICARE coverage must be terminated if and when issued by this Group Medical Plan.)*	☐	☐
If yes, Name: _____		
Type of coverage: ☐ Group ☐ Individual ☐ Other *(specify):* _____		
Insurance Co: _____		
Date coverage began: _____ Date ended: _____		
3. Does any person applying for coverage currently have Dental Insurance Coverage?	☐	☐
If yes, Type: _____ Insurance Co: _____		
Date coverage began: _____ Date ended: _____		
4. Is any person applying for coverage eligible for Medicare?	☐	☐
If yes, Name: _____		

PROOF OF PRIOR COVERAGE *(Required)*

IMPORTANT – *Proof of coverage must accompany this application for pre-existing condition credit.*

Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of I.D. Card ***AND*** copy of the most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier. UNICARE will assist in obtaining this information on your behalf should the need arise. Pre-existing conditions are diseases or conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the eligibility date; the exclusion extends for not more than 12 months and the exclusion is reduced by the aggregate of the periods of prior creditable coverage.

8. AUTHORIZATION *(The following Authorization is to be signed by all employees applying for coverage.)*

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage is issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours per week.

I understand that my eligible employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been accepted and approved by UNICARE.

I understand that the policy applied for will not pay the benefits for the first 12 months for the treatment of any condition which existed before the effective date of my coverage.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy or your coverage under the policy being rescinded or re-evaluated, as of the effective date, for eligibility and rating purposes. Any person who knowingly presents a false or fradulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I am applying for Participating Provider Plan coverage: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

Authorization to obtain or release Certificate of Creditable Coverage or medical information: I authorize any health plan, physician, clinic, hospital, health care professional, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other healthcare provider, ("My Providers") that has provided payment, treatment or services to me or any or 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 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 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.

NOTICE: All doctors, hospitals and providers listed in the Directory of Providers are independent contractors. They are not agents or employees of UNICARE. When you or a covered member of your family select a Primary Care Physician or seek care from a network provider, either directly or by referral from another provider, you are seeking care from that provider, not from UNICARE. UNICARE does not control, nor does it have a right to control, any aspect of a provider's medical judgement. UNICARE's decisions about whether any medical service or supply is covered under your health plan are insurance benefit decisions only and are not the provision of medical care. UNICARE is not responsible for, does not provide, and does not hold itself out as a provider of, medical care. Only the doctors who treat you and your family can provide medical care, and only those doctors are responsible for any negligence in providing that medical care. If a service or supply is not eligible for benefits, you and your provider are free to proceed with that service or supply knowing that benefits are not available under your health plan.

I, the applicant, acknowledge that I have read and understand this application in its entirety.

NAME OF EMPLOYEE *(Please Print)*

NAME OF EMPLOYEE'S SPOUSE *(Please Print)*

SIGNATURE OF EMPLOYEE *(Required)*	TODAY'S DATE *(Required)*
X	

SIGNATURE OF EMPLOYEE'S SPOUSE *(If applying for coverage)*	TODAY'S DATE *(Required)*
X	

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

UNICARE®