UniCare

2-99 SMALL GROUP EMPLOYEE APPLICATION

Medical, Dental Coverage and 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)
_____

Please Note: You may have the option to choose a Consumer Choice of Benefits Health Insurance Plan, that either in whole or in part, DOES NOT PROVIDE STATE-MANDATED HEALTH BENEFITS NORMALLY REQUIRED IN ACCIDENT AND SICKNESS INSURANCE POLICIES IN TEXAS. A standard health benefit plan 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 benefit plan, please consult with your insurance agent to discover which state mandated health benefits are excluded from the plan.

1. COVERAGE

A. MEDICAL COVERAGE SELECTION *Check only one.*

Performance Choice Plus
Performance Choice
- ☐ Performance Choice Plus 500
- ☐ Performance Choice Plus 1000
- ☐ Performance Choice Plus 2000
- ☐ Performance Choice 2500
- ☐ Performance Choice Saver 1000

Consumer Choice
- ☐ Consumer Choice 1000
- ☐ Consumer Choice 2500
- ☐ Consumer Choice HSA Compatible 2600
- ☐ Consumer Choice Saver 2000

HSA Compatible
- ☐ UniCare HSA Compatible A
- ☐ UniCare HSA Compatible B
- ☐ UniCare HSA Compatible C
- ☐ UniCare HSA Compatible D

Pathways
- ☐ Pathways Advantage
- ☐ Pathways Plus
- ☐ Pathways Essentials

Solaura
- ☐ UniCare Solaura HIA
- ☐ UniCare Solaura HIA+ A
- ☐ UniCare Solaura HIA+ B
- ☐ UniCare Solaura HIA+ C
- ☐ UniCare Solaura HIA+ D
- ☐ UniCare Solaura HSA E
- ☐ UniCare Solaura HSA F
- ☐ UniCare Solaura HSA G
- ☐ UniCare Solaura HSA H
- ☐ UniCare Solaura HSA I

B. DENTAL COVERAGE SELECTION *Check only one.*

High Options
- ☐ High Option FFS
- ☐ GoldPremium

Medium Options
- ☐ Standard FFS
- ☐ GoldPlus
- ☐ GoldStandard

Low Options
- ☐ Basic FFS
- ☐ SilverStandard

Voluntary Options
- ☐ UniCare VB
- ☐ UniCare VS

C. LIFE AND DISABILITY COVERAGE SELECTION *Check all that you are applying for. Coverage is limited to what is selected and offered by the employer.*

- ☐ Basic Term Life & AD&D
- ☐ Dependent Life
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Supplemental Life
  - ☐ $15,000
  - ☐ $25,000
  - ☐ $50,000
  - ☐ $100,000*

  [*Available to groups of 10 or more enrolling employees]
- ☐ SecurePack

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 ☐ State Continuation

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)		APT. NO.		HOME PHONE NO.
CITY	STATE	ZIP CODE		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 ☐ Annually	LIFE INSURANCE BENEFICIARY Last Name, First Name, Middle Initial	RELATIONSHIP	AGE

Please Note: If any dependent has a different address, please write the dependent's name, relationship to the employee, and address on a separate sheet and attach to this application.

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 who are under age 25; adopted children under age 25, including a child for whom the Eligible Employee is a party in a suit to adopt; or grandchildren who are under age 25 and are dependents for federal income tax purposes at the time of application.

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.

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

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
- ☐ Other (Explain): _____

B. Dental Coverage declined for: ☐ Myself ☐ Spouse ☐ Dependent(s) ☐ Spouse and Dependent(s)

C. Life Insurance declined for: ☐ Myself ☐ Dependent(s)

D. Short Term Disability declined: ☐ Myself Reason: _____

E. Long Term Disability declined: ☐ Myself Reason: _____

F. SecurePack declined: ☐ Myself Reason: _____

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 (unless employee and/or dependent(s) have group medical coverage elsewhere*), I acknowledge that if I wish to enroll at a later date, my dependent(s) and I will have to wait until the next open enrollment period in this group medical and/or group life insurance plan. Preexisting conditions may not be covered for twelve (12) months.

X _____ _____

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

* If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your other coverage or your dependents' other coverage). However, you must request enrollment within 31 days of the date your other coverage or your dependents' other coverage ends (or within 31 days of the date the employer stops contributing toward the other coverage). 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. However, you must request enrollment within 31 days of the date of the marriage, birth, adoption or placement for adoption.

5. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 2 - 50 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 any signs or symptoms, had a consultation for, received advice for, sought diagnosis or treatment for, had treatment recommended 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 ON THE PREVIOUS PAGE, 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.
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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 51-99 EMPLOYEES

	Yes	No
1. Within the last 10 years, has any person on this application had any signs or symptoms, had a consultation for, received advice for, sought diagnosis or treatment for, had treatment recommended for, received treatment (including medication) for, or been hospitalized for any of the following conditions:		
a. Cardiovascular disease or heart disorders, strokes, 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 or cancer?	☐	☐
b. Immune deficiency disorder, AIDS, AIDS related complex or been diagnosed as HIV positive?	☐	☐
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 _____

Treating providers, 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 _____

Treating providers, 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?	☐	☐

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 preexisting condition credit.*

Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of medical premium bill from prior carrier showing first month's premium and last month's premium.
3. Copy of front and back of insurance card; phone number of prior carrier and completed HIPAA authorization form (available upon request) giving us permission to obtain prior coverage information from previous carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full preexisting conditions limitation with no credit for prior coverage. You are entitled to a Certificate of Creditable Coverage from your prior carrier. UniCare will assist in obtaining this information on your behalf should the need arise. Preexisting conditions are signs, symptoms, 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/DISCLOSURE STATEMENT *(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 my contribution, if any, from my earnings towards 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 represent that I have read this application and that even if this application is approved by UniCare, any misstatements or omissions on this application, regarding me or my spouse, as applicable, may result in future claims being denied, or my coverage and/or my spouse's coverage under the policy being rescinded or re-evaluated retroactive to the policy's effective date for eligibility and/rating purposes.

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.

The Consumer Choice Plan(s) do not provide some state-mandated health benefits. For Groups with no more than 50 eligible employees, state-mandated benefits not included are: 1) Serious Mental Illness; 2) Oral contraceptives, prescription contraceptive drugs and devices and related services (unless the plan includes maternity benefits); 3) Chemical Dependency; 4) In-Vitro fertilization, and 5) Speech and Hearing. In addition, coinsurance differentials are greater than 30 percent. 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.

The Consumer Choice Plan(s) do not provide some state-mandated health benefits. For Groups with more than 50 eligible employees, state-mandated benefits not included are: 1) Telemedicine/Telehealth; 2) Chemical Dependency; 3) In-Vitro fertilization, and 4) Speech and Hearing. In addition, coinsurance differentials are greater than 30 percent. 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.

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 Life & Health Insurance Company (UniCare), including UniCare or its designated agent. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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

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.

I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for that coverage has not been made by my employer.

I understand that I am entitled to a copy of this signed authorization if I request it.

Arbitration Agreement: I understand that any dispute between me and UniCare may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing such arbitration.The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the policyholder or, if applicable, beneficiary resides. By signing this application, I am not agreeing to binding arbitration. If I am enrolling in an Employer-sponsored plan that is subject to ERISA, I understand that any dispute involving an adverse benefit decision may be submitted to voluntary binding arbitration only after the ERISA appeal process is completed.

☐ This application was completed by someone other than me. I, the applicant, represent that I have read all the information provided as responses in this application and represent and warrant to UniCare that such information is true, complete and accurate as of the current date, and that if I had made this application out on my own, the information provided on the application would remain the same.

☐ I completed this application. I, the applicant, represent to UniCare that I have read all the information provided in response to the questions on this application and I represent to UniCare that such information is true, complete and accurate as of the current date.

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

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

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

MEDICAL PREEXISTING CONDITION EXCLUSION NOTICE

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to UniCare Life & Health Insurance Company, Small Group Services, at P.O. Box 5053, Bolingbrook, IL 60440-5053 or call (888) 747-4535.

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