



Individual and Family  
Plans

# Individual High Deductible (MSA Compatible) Health Plans

# *UNICARE offers MSA compatible*

This is only a brief description of the plans. For complete details, including benefits, limitations, and exclusions, please refer to the applicable Certificate of Coverage. Should there be any discrepancies between this brochure and the Certificate of Coverage, the Certificate of Coverage shall govern.

# *health plans so you can choose the right coverage for you and your family.*

## *What Is a High Deductible (MSA Compatible) Health Plan?*

An annual deductible is the amount you pay each year before your insurance plan begins to pay benefits for expenses covered by your health plan. A High Deductible (MSA Compatible) Plan provides you with coverage for catastrophic medical occurrences that exceed the amount of your deductible. Since the premiums are usually lower on High Deductible Plans, you can deposit the money you save into a Medical Savings (MSA) Account to cover your lower-cost, routine care.

## *What Is an MSA?*

A Medical Savings Account (MSA) is a tax-favored account set up to pay for medical care and to allow for the build-up of savings to pay for future medical expenses.

In combination with a High Deductible Health Plan, it gives you a way to fund your health expenses now and save for long-term care expenses or to bridge the gap caused by the uncertain future of Medicare.

The High Deductible (MSA Compatible) Health Plans are provided by UNICARE Life & Health Insurance Company (referenced herein as UNICARE). The Medical Savings Account is not administered by UNICARE and you may choose any MSA-qualified financial institution that provides this service.

**UNICARE Life & Health Insurance Company is a separately capitalized and incorporated subsidiary of WellPoint Health Networks Inc. WellPoint Health Networks Inc. is one of the largest managed care companies in the United States. WellPoint and its family of companies provide health coverage for over 13 million people and have over 42 million pharmacy benefits customers. UNICARE's High Deductible (MSA Compatible) Plans provide:**

- **Choice of doctors**
- **100% of covered expenses for UNICARE participating doctors once the deductible is satisfied**
- **Preventive care for children and adults**
- **Toll-free dedicated customer service numbers**
- **NO CLAIM FORMS with Network Providers**
- **Optional easy-issue Term Life Insurance**

## *Your Deductible Options*

By law, the deductible of the health plan you choose directly affects the amount you may deposit into your MSA each year. UNICARE offers you the choice of a Single Party Plan (for you as an individual) or a Family Plan (for you and your family). You may choose a \$2,500 deductible for yourself or a \$4,950 deductible for yourself and your family.

Individuals can deposit annually up to 65% of their deductible into their MSA, which is \$1,625 for the \$2,500 deductible plan. Families can deposit annually up to 75% of their deductible. This is \$3,712.50 for the \$4,950 deductible plan.

<b>Your Plan</b>	<b>Deductible</b>	<b>Annual Amount You May Deposit In Your MSA</b>
<b>Single Party</b>	<b>\$2,500.00</b>	<b>\$1,625.00</b>
<b>Family</b>	<b>\$4,950.00</b>	<b>\$3,712.50</b>

In addition, your maximum allowable annual deposit is reduced proportionately if you were not covered under the High Deductible (MSA Compatible) Plan for the entire year. For example, if your plan goes into effect July 1, you can only contribute 50% of the respective maximum amount in that calendar year.

## *What Is the Advantage of Having the MSA?*

Your UNICARE High Deductible (MSA Compatible) Plan pays benefits for certain

covered medical services once your deductible is satisfied. The funds you deposit into your MSA can be used to pay for these covered expenses applied to your deductible.

There may be some other medical expenses not covered by this High Deductible Plan that may allow you to use the funds deposited into your MSA to cover these charges without penalty. Please refer to section 213(d) of the IRS Code for information regarding what medical expenses can be covered by your MSA.

## *Eligibility*

To enroll in a UNICARE High Deductible Plan, you must be eligible to open a qualified MSA.

UNICARE's determination of eligibility for coverage is not a determination that you are qualified to establish and/or maintain a Medical Savings Account. You should consult with your tax or legal advisor to determine if you are eligible under the law to establish and/or maintain an MSA.

## *Apply for Your UNICARE*

### *High Deductible Plan Now*

You must first enroll in a High Deductible Health Plan before you can establish a Medical Savings Account. Because you must have a High Deductible Health Plan to open an MSA, *be sure you are accepted into the UNICARE Individual High Deductible (MSA Compatible) Health Plan BEFORE you open your MSA.* You must continue your enrollment in your High Deductible Plan in order to continue making contributions into your MSA

## **IMPORTANT NOTE:**

**UNICARE High Deductible Plans are not MSAs. The MSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. You must be an "eligible" individual under IRS regulations to receive the MSA tax benefits. The IRS has not yet issued MSA or High Deductible Health Plan regulations or determined that UNICARE High Deductible Plans are qualifying High Deductible Health Plans. Consultation with a tax advisor is recommended before you decide on applying for a UNICARE High Deductible Plan.**

## UNICARE HIGH DEDUCTIBLE SINGLE PARTY AND FAMILY PLANS

These catastrophic medical plans provide quality coverage for eligible medical expenses both in and out of the hospital. These plans are provided under a policy issued to the UNICARE Classic Trust II. You participate under the policy as a participant in the trust.

### Benefit Summary

	Single Party Plan	Family Plan
Lifetime maximum benefit per member	\$5,000,000	\$5,000,000
Calendar-year deductible	\$2,500	\$4,950 (per family)
Out-of-pocket maximum (includes calendar-year deductible and out-of-network coinsurance)	\$3,300	\$6,050 (per family)

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### UNICARE Protects You From Catastrophic Expenses

#### For covered expenses when you use UNICARE participating doctors and hospitals

##### You Pay

The amount of your calendar-year deductible.

##### UNICARE Pays

100% of eligible charges after the deductible is satisfied.

#### For covered expenses when you use nonparticipating doctors and hospitals

##### You Pay

The amount of your calendar year deductible. Thereafter, you pay 40% coinsurance to a maximum additional out-of-pocket of \$800 for the Single Party Plan and \$1,100 for the Family Plan, plus any amounts over covered expenses.

##### UNICARE Pays

60% of eligible charges until your out-of-pocket maximum is reached, then 100% of covered expenses thereafter in a calendar year.

#### Example Only: It pays to use a UNICARE Participating Physician or Hospital

Participating Providers		Nonparticipating Providers	
If the billed charges are	\$1,000	If the billed charges are	\$1,000
And UNICARE's negotiated rate is	\$650	Amount UNICARE considers reasonable	\$650
You get a discount of	\$350	You pay (40% of reasonable charges*)	\$260
UNICARE payment 100% of negotiated fee*	\$650	Plus, the difference between the billed charges and the reasonable charges	\$350
<b>You pay</b>	<b>\$0</b>	<b>You pay a total of</b>	<b>\$610</b>

\*Assuming any deductible has been met and you have not reached your annual out-of-pocket maximum.

### Your Share of Costs

The benefits outlined in the table on pages 4 and 5 show your share of payment for covered expenses after you have satisfied your deductible and prior to the coinsurance limit being reached. When you use UNICARE in-network (participating) providers, your costs are based on a specially negotiated rate for UNICARE that may often save you money. Remember that covered expenses may be significantly less than the actual billed charges when you use out-of-network providers. (Out-of-network covered expenses will be paid at reasonable charges). Refer to the UNICARE provider directory to determine which providers in your area are participating providers. Your agent should give you a list of participating providers before you sign an application for coverage.

## UNICARE Individual High Deductible Single Party and Family Plans - Summary of Benefits

### Your Share of Costs for Covered Expenses

Your Plan Features	After payment of your annual deductible, when you use UNICARE providers, you pay:	After payment of your annual deductible, when you use non-UNICARE providers, you pay the percentage of reasonable charges: <sup>1</sup>
<b>Professional Services</b> Office visits, surgery, anesthesia, radiation therapy, in-hospital doctor visits, and diagnostic x-ray and lab	0	40%
<b>Preventive Care</b> For Babies/Children (through age 6): Exam, immunization, labs	0	40%
For Adults: Routine Pap smears, annual mammograms, colorectal cancer screenings and PSA (Prostate Specific Antigen) tests for men, and the related exam	0	40%
<b>Outpatient Medical Care</b> <sup>2</sup>	0	40%
<b>Physical/Occupational Therapy/Medicine</b>	Charges over \$25 per visit, up to 12 visits per year.	
<b>Acupuncture/Acupressure</b>	Charges over \$25 per visit, up to 12 visits per year.	
<b>Mental, Emotional, or Functional Nervous Disorders and Treatment of Alcoholism</b>  Inpatient hospital charges <sup>3</sup> In- or outpatient professional charges	Your share of costs for covered expenses for Mental, Emotional, or Functional Nervous Disorders, and the Treatment of Alcoholism is the same as any other medical condition.	
<b>Smoking Cessation</b>	Charges over \$50 for pharmaceuticals per lifetime, per insured and over \$50 for other covered services per lifetime, per insured for any smoking cessation program.	
<b>Infusion Therapy</b> <sup>4</sup> (Administration of drugs and other substances through methods other than oral, such as chemotherapy through a vein.)	0	40%
<b>Durable Medical Equipment</b>	0	40%
<b>Inpatient Hospital Services</b> <sup>3</sup>  Surgery, x-rays, in-hospital doctor visits, organ/tissue transplant <sup>5</sup>	0	40% and an additional \$500 deductible per continuing hospital confinement for non-emergency stays.  40%
Inpatient medical emergency/emergency medical condition <sup>3</sup>	0	Nothing until no longer a medical emergency. Then 40% and a \$500 deductible per continuing hospital confinement.
<b>Ambulatory Surgical Center</b> <sup>6</sup>	0	40%
<b>Ambulance Service</b>	Charges over UNICARE's maximum covered expense of \$750 per trip (air or ground).	40% and charges over UNICARE's maximum covered expense of \$750 per trip (air or ground).
<b>Home Health Care</b> <sup>5</sup> (limit of 60 visits per year)	0	40%
<b>Skilled Nursing Facilities</b> <sup>5</sup> (limit of 100 days per year)	Charges over UNICARE's maximum covered expense of \$400 per day	40% and charges over UNICARE's maximum covered expense of \$400 per day
<b>Hospice</b> <sup>5</sup> (\$10,000 lifetime maximum)	0	40%

## Your Share of Costs for Covered Expenses

Pharmacy Maximum 30-day supply	Participating pharmacy, paid based on UNICARE negotiated rate, you pay:	Non-participating pharmacy, paid based on the average wholesale price of the drug, you pay:
Generic/Brand Name drugs	0	50%

### Utilization Review/Authorization/Penalties

This program provides you with valuable information about the medical necessity of services, helping you avoid both unexpected out-of-pocket costs and unnecessary procedures. Utilization review may take place prior to admission to a hospital or ambulatory surgical center, during a hospital stay, or following a discharge from a hospital or ambulatory surgical center.

An important aspect of this program is preservice review. The following medical procedures must be reviewed for medical necessity through a preservice review: all non-emergency inpatient hospital stays and non-emergency outpatient surgeries at an ambulatory surgical center. You must initiate a preservice review at least 3 working days prior to admission. There are penalties for proceeding without a preservice review, as described below.

- 1 In addition to the percentage of reasonable charges you pay, you must also pay any amounts above reasonable charges.
- 2 Emergency room visits that do not result in inpatient admissions will require an **additional \$30 deductible**.
- 3 Inpatient medical care has an **additional \$250 penalty** without preservice review. This penalty is waived on emergency admissions; however, utilization review is still required.
- 4 Infusion Therapy must be preauthorized by UNICARE. Covered expense includes professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment, and training related to Infusion Therapy. It will not exceed: Total Parenteral Nutrition (with or without lipids), \$250 per day; Antibiotics, Average Wholesale Price (AWP) + \$125 per day; Chemotherapy, AWP + \$150 per day; Pain Management, \$125 per day; Aerosol Therapy, AWP + \$70 per day; Tocolytic Therapy, \$250 per day; Special Items, AWP; and Intravenous Hydration, \$75 per day. Failure to obtain authorization will result in an **additional \$1,000 penalty**.
- 5 In addition to preservice review, you will pay an **additional \$1,000 penalty** unless UNICARE authorizes benefits before you receive services. This applies to: Organ/Tissue Transplants, Infusion Therapy, Home Health Services, Skilled Nursing Facilities, and Hospice.
- 6 All surgical services of an ambulatory surgical center require preservice review or you pay an **additional \$50 penalty**. Ambulatory surgical centers must be licensed and accredited, and must meet all requirements of state and local laws and agencies.

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### Additional Waiting Periods

An insured person must be covered by the plan for 6 consecutive months to be eligible for payment for removal or treatment of hernia (except strangulated or incarcerated) and varicose veins.

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### Pre-existing Condition

For medical conditions that existed 6 months prior to the effective date, there will be no coverage for such conditions for 12 months after the effective date.

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**READ YOUR CERTIFICATE OF COVERAGE CAREFULLY. This summary of benefits provides a very brief description of the important features of your plan. This brochure is not the insurance contract and only the actual plan provisions will apply. The Certificate of Coverage itself sets forth, in detail, the rights and obligations of both you and your insurance company. The terms of the Certificate of Coverage govern all benefit determinations. It is, therefore, important that you READ YOUR CERTIFICATE OF COVERAGE CAREFULLY.**

### *Who Is Eligible for Coverage?*

Self-employed individuals have the option of either a Single Party Plan or a Family Plan.

#### **Single Party Plan**

- You, if you're under age 64 1/2.  
(No dependent coverage available.)

#### **Family Plan**

To be eligible for enrollment, you must be:

- Age 64 1/2 or younger
- The applicant's spouse, age 64 1/2 or younger
- The applicant's unmarried child up to age 19
- The applicant's unmarried child who is a full-time student (12 units per semester), age 19 through 22
- A resident of the United States for at least six months
- Able to meet UNICARE's underwriting guidelines
- Not eligible for Medicare
- Not enrolled under any other group or non-group health policy.

### *Enrollment and Review Process*

Each individual and family member who applies for coverage in any of the UNICARE plans must submit an individual application for UNICARE underwriting review. If any applicant does not qualify based on UNICARE's underwriting standards, the application will not be approved. Certain conditions, subject to UNICARE's underwriting guidelines, may qualify the applicant for the plan at a premium that is higher than the Level 1 (preferred) premium. The preexisting condition exclusion is still applicable for 12 months following the effective date of coverage. Follow the instructions on the Individual Application form.

### *Important Additional Information*

#### **10-Day Free Look**

Once your Certificate of Coverage arrives, you have 10 full calendar days to examine and either accept or decline by returning the Certificate of Coverage.

#### **Balanced Risk Keeps Your Costs Low**

UNICARE believes in fairness. We believe the cost of covering someone with minimal health care needs should not be unfairly offset by someone whose health can be predicted to require costly care. UNICARE maintains this risk balance by evaluating all individuals who apply for coverage with the same underwriting review criteria. If the applicant does not qualify for the particular coverage applied for, the application will be declined or approved with increased premium.

#### **Terms of Coverage**

Coverage under this plan remains in force as long as the required premiums are paid on time and as long as the insured remains eligible for coverage. Coverage ceases when an insured becomes ineligible because of divorce or a change in dependent status. (In the case of divorce and over-age dependents, UNICARE may offer a similar plan.) UNICARE may change the premiums of this plan after 30 days written notice to the insured. However, UNICARE will not change the premium schedule for this plan on an individual basis, but only for all insureds in the same class and covered under the same plan as you.

#### **Rates**

Medical rates are calculated based on the age of the applicant or spouse, whoever is older, and the residence address. Rates are recalculated at each billing period based on age and the residence address. See pages 10-12 for medical coverage rates.

## **UNICARE Term Life Insurance (Optional coverage)**

Coverage underwritten by UNICARE Life & Health Insurance Company

Life insurance provides a financial safety net for the people who depend on you. Once you qualify for a High Deductible Plan, you may also choose Term Life Insurance. For just a few cents more per day, you'll have the security and peace of mind that you can help meet your family's financial needs even if you're not there to provide for them. You may also choose life insurance for your eligible family members. It's as easy as checking a box on your application form and completing the Term Life Application Addendum on the last page of the brochure.

The rates for Term Life Insurance will change based on the applicant's age and the age categories shown in the chart below. The policy is issued for a one-year term, renewable at the policyholder's option. The rate schedule may be changed at the beginning of any annual term.

The policy will be canceled automatically on the first day of the month of the policyholder's 65th birthday. If that birthday falls on the first of the month, the policy will be canceled on the first day of the month prior to the birth month.

The Term Life Insurance coverage is subject to the written provisions of the policy issued by UNICARE. Please refer to the policy for more complete details including benefits, limitations, and exclusions.

Each family member who has elected the Term Life Insurance option will be sent a separate policy.

<b>Coverage Amounts</b>	
<b>Age</b>	<b>Amount</b>
19 through 64	\$15,000
	25,000
	50,000
1 through 18	\$15,000
	25,000
Under 1	Not available

<b>Monthly Rates</b>			
<b>Age</b>	<b>\$15,000</b>	<b>\$25,000</b>	<b>\$50,000</b>
1-18	\$1.50	\$2.50	N/A
19-29	2.80	4.65	9.30
30-39	3.25	5.40	10.80
40-49	7.50	12.50	25.00
50-59	20.90	34.80	69.60
60-64	29.40	49.00	98.00

## Excluded Services

### Exclusions and Limitations

The Plan does **not** provide benefits for:

- Any amounts in excess of maximum amounts of Covered Expenses.
- Services not specifically listed in the Plan as Covered Services.
- Services or supplies that are not Medically Necessary.
- Services or supplies that UNICARE considers to be Experimental or Investigative Procedures.
- Services received before the Effective Date of coverage or during an inpatient stay that began before the Effective Date.
- Services received after coverage ends.
- Services for which You have no legal obligation to pay or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement, or otherwise, under any Workers' Compensation, employer's liability law, or occupational disease law, even if You do not claim those benefits.
- Any intentionally self-inflicted injury or illness.
- Conditions caused by (a) an act of war; (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a felony or as a direct result of the Insured Person being engaged in an illegal occupation; (f) an Insured Person, being under the influence of illegal narcotics or non-prescribed controlled substances unless administered on the advice of a Physician.
- Any services provided by a local, state, or federal government agency except when payment under this plan is expressly required by federal or state law.
- If you are eligible for Medicare, any services covered by Medicare under Part A and B are excluded from consideration of payment regardless of actual enrollment in Medicare or payment by Medicare for those services.
- Any services for which payment may be obtained from any local, state, or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current law.
- Professional services received, or supplies purchased from, Yourself, a person who lives in the Insured Person's home or who is related to the Insured Person by blood, marriage or adoption, or the insured person's employer.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change, physical therapy, or treatment of chronic pain; custodial care or rest cures; services provided by a rest home, a home for the aged, a nursing home, or any similar facility service.
- Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Treatment of drug or other substance addiction or abuse.
- Dental services.
- Orthodontic Services.
- Dental Implants or any associated procedure.
- Hearing aids.
- Routine hearing tests except as provided under Well Baby and Well Child Care.
- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in the Plan.
- An eye surgery solely for the purpose of correcting refractive defects of the eye.
- Outpatient speech therapy.
- Any drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in the Plan. This includes, but is not limited to, items dispensed by a Physician.
- Cosmetic surgery or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a newborn child, or to Medically Necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical, or psychiatric treatment or study related to sex change.
- Treatment of sexual dysfunction, impotence and/or inadequacy.
- All services related to the evaluation or treatment of fertility and/or infertility including, but not limited to, all tests, consultations, examinations, medications, and invasive medical, laboratory, or surgical procedures including sterilization reversals and in vitro fertilization.
- All contraceptive services and supplies including but not limited to all consultations, examinations, evaluations, medications, medical, laboratory, devices, prescription drugs, or surgical procedures.
- Cryopreservation of sperm or eggs.
- Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.

- Services primarily for weight reduction or treatment of obesity or any care which involves weight reduction as a main method for treatment except as specifically stated in the Plan.
- Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority.
- Charges by a provider for telephone consultations.
- Items which are furnished primarily for Your personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, etc.).
- Educational services except for diabetes self-management training and as specifically provided or arranged by UNICARE.
- Nutritional counseling or food supplements except for medical nutrition care for diabetes.
- Durable medical equipment not specifically listed in the plan.
- Any services received on or within twelve months after the Effective Date of coverage if they are related to a Pre-existing Condition.
- Incidental supplies used by a provider in the administration of Infusion Therapy except where specifically stated in the Plan.
- Foreign Country Provider charges except as specifically stated in the Plan.
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition.
- Routine foot care including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet.
- Charges for which We are unable to determine Our liability because You or an Insured Person failed, within 60 days, or as soon as reasonably possible to (a) authorize Us to receive all the medical records and information We requested or, (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for animal to human organ transplants.
- Charges for normal pregnancy or maternity care, including normal delivery, elective abortions and elective non-emergency cesarean sections, as long as the service is not related to complications of pregnancy.
- Drugs and medications not requiring a Prescription, except insulin.
- Non-medical substances or items, with the exception that pharmaceuticals to aid smoking cessation are covered up to a Lifetime Maximum payment of \$50 per Insured Person.
- Drugs and medications to induce non-spontaneous abortions.
- Dietary supplements, cosmetics, health or beauty aids.
- Any vitamin, mineral, herb or botanical product which is thought to have health benefits, but does not have an FDA (Food and Drug Administration) approved indication to treat, diagnose or cure a medical condition.
- Any expense incurred in excess of the UNICARE Negotiated Rate.
- Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications (such as progesterone suppositories).
- Syringes and/or needles except those dispensed for use with insulin and covered self-administered injectable drugs.
- Drugs used for cosmetic purposes.
- Drugs used for the primary purpose of treating Infertility or promoting infertility.
- Anorexiant or drugs associated with weight loss.
- Drugs obtained outside the United States.
- Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Waiver, Pre-existing Condition, or other contract limitation.
- Prescription Drugs with a non-prescription (over-the-counter) chemical and dose equivalent.
- Lost or stolen Prescriptions.

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### ***Area Residence ZIP Codes***

Find either your ZIP code or the first three digits of your ZIP code.

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Area 1	46303, 46307, 46308, 46311, 46312, 46319-46324, 46342, 46356, 46373, 46375, 46394, and all ZIP codes beginning with 464
Area 2	All other 463 ZIP codes
Area 3	All ZIP codes beginning with 462, 465, and 466
Area 4	Rest of state

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### ***Certain Medical Conditions***

For certain medical conditions, an applicant may qualify for a plan at a premium that is higher than the level 1 rates.

### ***Tobacco Users***

Tobacco users pay an additional 40 percent premium. If any family member who is to be insured uses tobacco, see the Level 1+40 percent rates.

### ***Additional Information***

- Rates are based on the age of the applicant or spouse, whoever is older, and the residence address.  
Rates are recalculated at each billing period based on age and the residence address.
- Payment methods are
  - 1) monthly by checking account deduction on the first of each month or
  - 2) 3-month (quarterly) billing.

# Indiana High Deductible Plans Monthly Rates

The Single Party Plan deductible is \$2,500. The Family Plan deductible is \$4,950.

## Level 1

	Area 1	Area 2	Area 3	Area 4
<b>Single Male</b>				
Under 30	67	62	56	51
30-34	78	72	66	59
35-39	95	87	80	72
40-44	119	109	100	90
45-49	158	145	133	120
50-54	195	179	164	148
55-59	266	245	223	202
60-64	326	300	274	248
<b>Single Female</b>				
Under 30	78	72	66	59
30-34	98	90	82	74
35-39	126	116	106	96
40-44	154	142	129	117
45-49	179	165	150	136
50-54	216	199	181	164
55-59	244	224	205	185
60-64	280	258	235	213
<b>Applicant &amp; Spouse</b>				
Under 30	134	123	113	102
30-34	143	132	120	109
35-39	173	159	145	131
40-44	208	191	175	158
45-49	266	245	223	202
50-54	321	295	270	244
55-59	417	384	350	317
60-64	497	457	417	378
<b>Applicant &amp; 1 Child</b>				
Under 30	130	120	109	99
30-34	150	138	126	114
35-39	178	164	150	135
40-44	206	190	173	157
45-49	231	213	194	176
50-54	267	246	224	203
55-59	318	293	267	242
60-64	378	348	318	287
<b>Applicant &amp; 2 Children</b>				
Under 30	181	167	152	138
30-34	200	184	168	152
35-39	228	210	192	173
40-44	256	236	215	195
45-49	281	259	236	214
50-54	318	293	267	242
55-59	368	339	309	280
60-64	428	394	360	325
<b>Applicant &amp; 3+ Children</b>				
Under 30	232	213	195	176
30-34	252	232	212	192
35-39	280	258	235	213
40-44	308	283	259	234
45-49	333	306	280	253
50-54	370	340	311	281
55-59	420	386	353	319
60-64	480	442	403	365
<b>Family w/ 1 Child</b>				
Under 30	179	165	150	136
30-34	188	173	158	143
35-39	218	201	183	166
40-44	259	238	218	197
45-49	318	293	267	242
50-54	372	342	312	283
55-59	469	431	394	356
60-64	549	505	461	417
<b>Family w/ 2 Children</b>				
Under 30	224	206	188	170
30-34	235	216	197	179
35-39	266	245	223	202
40-44	309	284	260	235
45-49	368	339	309	280
50-54	423	389	355	321
55-59	519	477	436	394
60-64	599	551	503	455
<b>Family w/ 3+ Children</b>				
Under 30	276	254	232	210
30-34	287	264	241	218
35-39	318	293	267	242
40-44	361	332	303	274
45-49	420	386	353	319
50-54	475	437	399	361
55-59	571	525	480	434
60-64	651	599	547	495
Child Under 1	80	74	67	61
Child 1-17	52	48	44	40
2 Children	102	94	86	78
3+ Children	154	142	129	117

## Level 1+40%

	Area 1	Area 2	Area 3	Area 4
<b>Single Male</b>				
Under 30	94	87	78	71
30-34	109	101	92	83
35-39	133	122	112	101
40-44	167	153	140	126
45-49	221	203	186	168
50-54	273	251	230	207
55-59	372	343	312	283
60-64	456	420	384	347
<b>Single Female</b>				
Under 30	109	101	92	83
30-34	137	126	115	104
35-39	176	162	148	134
40-44	216	199	181	164
45-49	251	231	210	190
50-54	302	279	253	230
55-59	342	314	287	259
60-64	392	361	329	298
<b>Applicant &amp; Spouse</b>				
Under 30	188	172	158	143
30-34	200	185	168	153
35-39	242	223	203	183
40-44	291	267	245	221
45-49	372	343	312	283
50-54	449	413	378	342
55-59	584	538	490	444
60-64	696	640	584	529
<b>Applicant &amp; 1 Child</b>				
Under 30	182	168	153	139
30-34	210	193	176	160
35-39	249	230	210	189
40-44	288	266	242	220
45-49	323	298	272	246
50-54	374	344	314	284
55-59	445	410	374	339
60-64	529	487	445	402
<b>Applicant &amp; 2 Children</b>				
Under 30	253	234	213	193
30-34	280	258	235	213
35-39	319	294	269	242
40-44	358	330	301	273
45-49	393	363	330	300
50-54	445	410	374	339
55-59	515	475	433	392
60-64	599	552	504	455
<b>Applicant &amp; 3+ Children</b>				
Under 30	325	298	273	246
30-34	353	325	297	269
35-39	392	361	329	298
40-44	431	396	363	328
45-49	466	428	392	354
50-54	518	476	435	393
55-59	588	540	494	447
60-64	672	619	564	511
<b>Family w/ 1 Child</b>				
Under 30	251	231	210	190
30-34	263	242	221	200
35-39	305	281	256	232
40-44	363	333	305	276
45-49	445	410	374	339
50-54	521	479	437	396
55-59	657	603	552	498
60-64	769	707	645	584
<b>Family w/ 2 Children</b>				
Under 30	314	288	263	238
30-34	329	302	276	251
35-39	372	343	312	283
40-44	433	398	364	329
45-49	515	475	433	392
50-54	592	545	497	449
55-59	727	668	610	552
60-64	839	771	704	637
<b>Family w/ 3+ Children</b>				
Under 30	386	356	325	294
30-34	402	370	337	305
35-39	445	410	374	339
40-44	505	465	424	384
45-49	588	540	494	447
50-54	665	612	559	505
55-59	799	735	672	608
60-64	911	839	766	693
Child Under 1	112	104	94	85
Child 1-17	73	67	62	56
2 Children	143	132	120	109
3+ Children	216	199	181	164



# Individual & Family High Deductible (MSA Compatible) Health Plans Life and Dental Plans Application



Individual and Family  
Plans

Thank you for applying with UNICARE.

## PLEASE NOTE:

- Coverage is not available if:
  - any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
  - the applicant has not resided in the U.S. for the last six (6) consecutive months.
- Coverage is not guaranteed until approved in writing by UNICARE. 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



# UNICARE® Individual Enrollment Application - Indiana

Applicant's Social Security No.								

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:

High Deductible (MSA Compatible) Single Party Plan (H004)       Life  
 High Deductible (MSA Compatible) Family Plan (H005)       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	✓ Dental
				Height	Weight				
<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	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	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:** \_\_\_\_\_

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**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**:

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

**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.)

<b>Question #</b>	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	

<b>Question #</b>	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	

<b>Question #</b>	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

DETACH HERE

## 7. Conditions of Application

Applicant's Social Security No.

**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 10, 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 \_\_\_\_\_.

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

As permitted by law, I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide UNICARE, its agents, or employees, including my UNICARE agent or broker, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below through the life of the plan. A photocopy of this Authorization is as valid as the original. My authorized representative, UNICARE agent, or I am entitled to receive a copy of this form.

I 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 11). 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 (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 HERE.  
DO NOT TAPE.

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

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

<b>8A. Initial Premium Payment by Credit Card</b>		<b>8B. Payment Type</b>	
New members only. Not available to make a coverage change.		<input type="checkbox"/> <b>Monthly Billing</b> (Available with Monthly Checking Account Deduction).	
Select one:	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	Initial Premium Amount	<ol style="list-style-type: none"> <li>1. Submit the one (1) month premium.</li> <li>2. Complete section 8C, <b>Monthly Checking Account Deduction Authorization</b>.</li> <li>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.</li> </ol>
Credit Card:	<input type="checkbox"/> VISA <input type="checkbox"/> MasterCard	\$	<input type="checkbox"/> <b>Quarterly Billing</b> – Submit the three (3)-month premium.
Credit Card No.	Expiration Date	<b>Please note:</b> First payment will be credited to approved applicants only.	
Cardholder's Name	Cardholder's ZIP Code		
Authorized Signature (as it appears on the credit card)	Today's Date		

**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**

DETACH HERE

**9. To be completed by your UNICARE-Appointed Agent**

<ul style="list-style-type: none"> <li>■ 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?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>■ Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:  _____</li> <li>■ I verify that this application was completed by the applicant unless the Statement of Accountability (Section 10) was completed. .... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>	<ul style="list-style-type: none"> <li>■ Breakdown of premium collected: Total Medical premium \$ _____</li> <li>Total Dental premium \$ _____</li> <li>Total Life premium \$ _____</li> <li><b>Total premium collected</b> \$ _____</li> <li>■ Was the Monthly Checking Account Deduction Authorization (Section 8C) completed? (only if applicable) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>■ Was a Conditional Receipt given? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>		
Name of Agent ( <i>Print Name</i> )		Agent's Street Address/Suite or Personal Mail Box No.	
Agent I.D. No.	Sub-Agent I.D. No.	City/State/ZIP Code	Location No.
Phone No. (      )	Fax No. (      )	E-mail Address	
Signature ( <i>Required</i> )		Date ( <i>Required</i> )	RSM Name
<p><b>Mail Plan to:</b> <input type="checkbox"/> Agent <input type="checkbox"/> Primary Applicant  <b>PLEASE NOTE:</b> If neither box is checked, the Plan will be mailed directly to the primary applicant.  <b>Mailing address:</b> Agent, please mail this application to: <b>UNICARE, P.O. Box 5030, Bolingbrook, IL 60440-5030</b></p>			

**10. 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*)

**11. Conditional Receipt – To be completed by the agent and given to the applicant.**

Received from \_\_\_\_\_ \$ \_\_\_\_\_ as a premium amount, 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 MONEY 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** \_\_\_\_\_  
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.



This is only a brief description of the plans. For complete details, including benefits, limitations, and exclusions, please refer to the applicable Certificate of Coverage.



UNICARE Life & Health Insurance Company  
Sales Office  
Bolingbrook, Illinois

Insurance coverage is underwritten by UNICARE Life & Health Insurance Company.  
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An application is required to be completed to apply for coverage and is subject to approval by UNICARE.

Rates effective 8/01/03

0006309IN 6/03