



2-99 GROUP EMPLOYER APPLICATION

Medical, Life, and Dental Coverage underwritten by UniCare Life & Health Insurance Company

FOR UNICARE USE ONLY

GROUP NO.

UNDERWRITER NO.

EFFECTIVE DATE

1. EMPLOYER INFORMATION - The employer certifies the following information.

COMPANY NAME			
STREET ADDRESS (P.O. Box not acceptable)		CITY	STATE ZIP
BILLING ADDRESS		CITY	STATE ZIP
EMPLOYER IS <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other-Explain:			
COMPANY CONTACT PERSON		PHONE NO. ()	FAX NO. ()
DATE BUSINESS WAS ESTABLISHED (Mo/Yr)	TYPE OF BUSINESS (Be specific)	E-MAIL ADDRESS	SIC CODE
Has the company been insured by UniCare in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior UniCare coverage terminated: _____			
Has the employer filed for bankruptcy in the past seven years? <input type="checkbox"/> Yes <input type="checkbox"/> No			

2. MEDICAL COVERAGE SELECTION - MemberFlexSM

All plans OR
 MemberFlex - designate specific plan options (check as many as apply)

Premier Flex Options	Flex Advantage Options	HSA-Compatible Options
<input type="checkbox"/> Premier Flex 500	<input type="checkbox"/> Flex Advantage 1000	<input type="checkbox"/> UniCare HSA-Compatible A
<input type="checkbox"/> Premier Flex 1000	<input type="checkbox"/> Flex Advantage 2000	<input type="checkbox"/> UniCare HSA-Compatible B
<input type="checkbox"/> Premier Flex 2000	<input type="checkbox"/> Flex Advantage 2500	<input type="checkbox"/> UniCare HSA-Compatible C
<input type="checkbox"/> Premier Flex 2500	<input type="checkbox"/> Flex Advantage Saver 2000	
<input type="checkbox"/> Premier Flex Saver 1000		

3. OPTIONAL MATERNITY RIDER

Maternity Rider* Add rider Decline rider N/A
(available with Flex Advantage plans and HSA-Compatible plans for groups with 2-14 employees)
 Maternity benefits are automatically included for groups with 15 or more employees.
 *Not applicable for Premier Flex plans, maternity benefits included within the plan.
 PLEASE NOTE: Maternity benefits MUST be offered consistently across all plan selections. (Groups with 2-14 employees that choose to offer Premier Flex plans MUST select the Optional Maternity Rider with any other plan options.)

4. DENTAL COVERAGE SELECTION - MemberFlexSM

<input type="checkbox"/> All plans OR <input type="checkbox"/> Designate specific plan options (Check as many as apply) <table border="0"> <tr> <td>High Options</td> <td>Medium Options</td> <td>Low Options</td> </tr> <tr> <td><input type="checkbox"/> High Option PPO</td> <td><input type="checkbox"/> Standard PPO</td> <td><input type="checkbox"/> Basic PPO</td> </tr> <tr> <td><input type="checkbox"/> High Option FFS</td> <td><input type="checkbox"/> Standard FFS</td> <td><input type="checkbox"/> Basic FFS</td> </tr> <tr> <td><input type="checkbox"/> Gold Premium</td> <td><input type="checkbox"/> GoldPlus</td> <td><input type="checkbox"/> SilverStandard</td> </tr> <tr> <td></td> <td><input type="checkbox"/> GoldStandard</td> <td></td> </tr> </table>	High Options	Medium Options	Low Options	<input type="checkbox"/> High Option PPO	<input type="checkbox"/> Standard PPO	<input type="checkbox"/> Basic PPO	<input type="checkbox"/> High Option FFS	<input type="checkbox"/> Standard FFS	<input type="checkbox"/> Basic FFS	<input type="checkbox"/> Gold Premium	<input type="checkbox"/> GoldPlus	<input type="checkbox"/> SilverStandard		<input type="checkbox"/> GoldStandard		Voluntary Selection <small>(Voluntary Dental is an alternative election and is not available in conjunction with the other plans.)</small> <input type="checkbox"/> UniCare VB <input type="checkbox"/> UniCare VS
High Options	Medium Options	Low Options														
<input type="checkbox"/> High Option PPO	<input type="checkbox"/> Standard PPO	<input type="checkbox"/> Basic PPO														
<input type="checkbox"/> High Option FFS	<input type="checkbox"/> Standard FFS	<input type="checkbox"/> Basic FFS														
<input type="checkbox"/> Gold Premium	<input type="checkbox"/> GoldPlus	<input type="checkbox"/> SilverStandard														
	<input type="checkbox"/> GoldStandard															

5. LIFE COVERAGE SELECTION - UniCare Life and AD&D Benefit Schedule.

Option A - \$15,000 Flat Amount for all employees
 Option B - Any Flat Amount higher than \$15,000, maximum \$250,000 \$ _____ **(Must be in increments of \$5,000)**
 Option C - Graded benefits by Job Title - **Class I:** Officers, managers, supervisors, \$30,000 - **Class II:** All other employees, \$15,000
 Option D - Graded benefits by Job Title - **Class I:** Officers, managers, supervisors, \$50,000 - **Class II:** All other employees, \$25,000
 Option E - Graded benefits by Job Title - **Class I:** Officers, managers, supervisors, \$100,000 - **Class II:** All other employees, \$50,000
 Dependent Life Option*: Yes No ***Must be completed if any of the above Life Benefit options are checked.**

5A. SUPPLEMENTAL LIFE BENEFIT SELECTION

Check if you are offering Supplemental Life Coverage to your employees.
 The Supplemental Life premium may be 100% employee paid.

FOR UNICARE USE ONLY

DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS
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6. RATING

Employers with 25 or more enrolling employees – choose one rating methodology

- Individual Rating** – each enrolling employee's rate depends on the employee's age, area, and family status.
- Composite Rating** – rating factors for all enrolling employees are combined, and average amounts are charged for the four family categories of Employee Only, Employee and Spouse, Employee and Children, or Full Family.

7. EMPLOYER CONTRIBUTION SELECTION

7A. MEDICAL CONTRIBUTION SELECTION

Check one:

- Defined Contribution 100*
- Defined Contribution 80**
- Defined Contribution Select*** \$ _____
- Traditional Contribution**** _____ %

* Employer contributes \$100 per employee per month.
 ** Employer contributes \$80 per employee per month.
 *** Employer selects contribution amount over \$100 per employee per month in \$5 increments.
 **** Employer selects contribution amount of 50% or more per employee per month.

7B. DENTAL CONTRIBUTION SELECTION

Check one:

- Defined Contribution 15*
- Defined Contribution Select** \$ _____
- Traditional Contribution*** _____ %
- Voluntary Contributions**** _____ %

* Employer contributes \$15 per employee per month.
 ** Employer selects contribution amount over \$15 per employee per month in \$5 increments.
 *** Employer selects contribution amount of 50% or more per employee per month.
 **** Employer selects contribution amount of 49% or less per employee per month.

7C. LIFE CONTRIBUTION SELECTION

- Employee Life Premium _____ %
- Dependent Life Premium _____ %

7D. SECTION 125 PREMIUM ONLY PLAN (P.O.P.) OPTION

- Check if you would like to enroll in P.O.P. (You must fully read the P.O.P. application booklet, complete the application form, and submit the completed form and separate enrollment check along with this Employer Application.)

8. EMPLOYEE ELIGIBILITY

Number of active full-time (30 hours per week) employees: _____

Number of **eligible** employees **declining** coverage: _____

Total number of eligible **enrolling** employees including COBRA/FMLA applicants: _____

Are all eligible employees (including owners) subject to withholding on a W-2 form? Yes No

Please explain: _____

Eligibility date is on the FIRST DAY of the month following the waiting period.

Waiting period for future employees: NONE 1 month 2 months 3 months 6 months

The following to be completed by groups of 20 or more total employees and/or employer providing continuation of coverage in accordance with Title X of COBRA:

Is your group subject to COBRA? Yes No

If yes, please complete the COBRA/FMLA Questionnaire.

The following question is to be completed by groups of 50 or more total employees and/or employer providing coverage in accordance with the Family and Medical Leave Act of 1993:

Is your group subject to FMLA legislation? Yes No

If yes, please complete the COBRA/FMLA Questionnaire.

9. CURRENT CARRIER – Is this plan intended to replace any existing group coverage?

HEALTH: Yes No If yes, name of group carrier: _____ Proposed termination date: _____

DENTAL: Yes No If yes, name of group carrier: _____

LIFE: Yes No If yes, name of group carrier: _____ Anniversary date: _____

10. EFFECTIVE DATE – Actual effective date will be assigned by UniCare underwriting department if policy is issued.

Requested effective date: _____

11. LEAVE OF ABSENCE

A. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence:

- None 1 month 2 months 3 months 4 months

B. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence

(maximum six months):

- None 1 month 2 months 3 months 4 months 5 months 6 months

It is the Employer's responsibility to immediately notify UniCare at the beginning of any authorized leave of absence.

12. MEDICAL INFORMATION

To your knowledge:

1. Is any employee to be covered unable to work due to injury or illness? Yes No

2. Is any employee unable to perform the normal duties of another person in the same employment class of the same age and sex? Yes No

If yes to either question, provide names: _____

13. WORKERS' COMPENSATION

Name of current Workers' Compensation carrier: _____ **Renewal date:** _____

Please list the name and job title of any person to be included as a subscriber under the UniCare coverage who is not an employee, for the purpose of Workers' Compensation law or similar legislation. Please note that under Indiana law, corporate officers are employees for Workers' Compensation purposes.

Name:	Title:	Exempt according to above requirements?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

14. SIGNATURE AND CONDITIONAL RECEIPT

Check the box that applies:

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA, apply to obtain the coverage indicated.

We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA, and therefore not subject to ERISA, apply to obtain the coverage indicated.

We represent that all information on this Application is true and complete, and that UniCare may rely on this Application in its decision to evaluate our group for eligibility and rating purposes. If not complete, UniCare reserves the right to reject the Application and notify us in writing. We understand and agree that coverage will be effective only if we have paid our first month's premium and have met eligibility criteria. We understand that we will be informed of acceptance and effective date in writing if this Application is issued, that we should keep prior coverage in force until so notified and that no agent or broker has the right to accept Application or bind coverage. This Application becomes a part of our contract with UniCare. **We verify that these answers are true and that coverage may be rescinded or re-evaluated for eligibility and rating purposes should it be determined at a future date that there are misstatements in these Application forms.**

Composite rates may be recalculated if a change in membership would otherwise result in a premium change for the group of more than 10%.

Dated at _____ on the _____ day of _____ 20____.

By X _____ Title _____
(Signature of Company Officer / Owner)

15. CONDITIONAL RECEIPT - Agent, please photocopy and give to your client.

This will acknowledge receipt of \$ _____ from _____

as a deposit against the insurance premiums that would become payable if UniCare Life & Health accepts this Application for group coverage. This check will be held in trust by UniCare pending acceptance or rejection of the Application. I have fully explained to the employer that in no event will benefits be payable for any loss incurred before the effective date assigned by UniCare Life & Health and that the company should retain any other coverage until then.

16. AGENT'S CERTIFICATION

- I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk.
- I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notification from UniCare the coverage being applied for by this application is issued.

1. NAME OF WRITING AGENT (Print or Type)	%	AGENT TAX I.D. NO.	(CHECK ONE) <input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
AGENT ADDRESS		PHONE NO. ()	FAX NO. ()
CITY / STATE / ZIP			
SIGNATURE OF AGENT X			DATE
2. NAME OF <input type="checkbox"/> SUB-AGENT <input type="checkbox"/> SECOND WRITING AGENT (Print or Type)	%	AGENT TAX I.D. NO.	(CHECK ONE) <input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
AGENT ADDRESS		PHONE NO. ()	FAX NO. ()
CITY / STATE / ZIP			
SIGNATURE OF SECOND AGENT X			DATE
3. NAME OF GENERAL AGENT		AGENT NO. (TIN)	

Send Administration Kit to: Agent Group