



2-99 GROUP EMPLOYEE APPLICATION

Medical, Dental Coverage and Life Insurance underwritten by UniCare Life and 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

1. COVERAGE

A. MEDICAL COVERAGE SELECTION – Check only one.

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		

B. DENTAL COVERAGE SELECTION – Check only one.

High Options	Medium Options	Low Options	Voluntary Selection
<input type="checkbox"/> High Option PPO	<input type="checkbox"/> Standard PPO	<input type="checkbox"/> Basic PPO	<input type="checkbox"/> UniCare VB
<input type="checkbox"/> High Option FFS	<input type="checkbox"/> Standard FFS	<input type="checkbox"/> Basic FFS	<input type="checkbox"/> UniCare VS
<input type="checkbox"/> Gold Premium	<input type="checkbox"/> GoldPlus	<input type="checkbox"/> SilverStandard	
	<input type="checkbox"/> GoldStandard		

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

D. SUPPLEMENTAL LIFE INSURANCE Yes No

Amount: \$15,000 \$25,000 \$50,000 \$100,000 * *Available to groups with 11 or more eligible employees.

2. EMPLOYEE INFORMATION – Must be completed by employee.

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

LAST NAME		FIRST NAME		M.I.	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> 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 \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	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.

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

If family addition is spouse, date of marriage: _____

RELATION	SEX	LAST NAME	FIRST NAME	M.I.	HEIGHT	WEIGHT	DISABLED?	BIRTHDATE			UNICARE USE ONLY						
								Month	Day	Year	Creditable Coverage						
Self	10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No										
Spouse	30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No										
	50 <input type="checkbox"/> Male 70 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No										
	51 <input type="checkbox"/> Male 71 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No										
	52 <input type="checkbox"/> Male 72 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No										
	53 <input type="checkbox"/> Male 73 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No										
	54 <input type="checkbox"/> Male 74 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No										

5A. IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ON 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. Include name of family member, nature of illness, dates and duration of treatment (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	<input type="checkbox"/> Still under treatment	ADDRESS	SUITE NO.
NAME OF CONDITION/ILLNESS			CITY / STATE / ZIP CODE	FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS			MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE	
QUESTION #	NAME OF FAMILY MEMBER (As identified on Physician's Record)		NAME OF HOSPITAL, CLINIC, AND OR PERSON PROVIDING CARE	PHONE NO. ()
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment	ADDRESS	SUITE NO.
NAME OF CONDITION/ILLNESS			CITY / SATE / ZIP CODE	FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS			MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE	
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NAME OF CONDITION/ILLNESS			CITY / STATE / ZIP CODE	FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS			MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE	

6. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 15-99 EMPLOYEES:

1. Within the last five years, has any person listed on this application had a consultation for, received medical advice for, been tested for, sought treatment for, had treatment recommended for, received treatment for (including prescription medication), been hospitalized for, or had any injury, impairment or illness related to 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; any disorder of the lungs or respiratory system; or cancer? Yes No

b. Immune deficiency disorder, AIDS or AIDS related complex or been diagnosed as HIV positive? Yes No

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? Yes No

3. Is any person listed on this application:

a. Currently under treatment, receiving counseling or taking medicine for any condition or disease? Yes No

b. Currently pregnant or is any male expecting a child with anyone, whether listed on this application or not? Yes No

If yes, due date (Month, Day, Year) _____

c. A user of tobacco products within the last 2 years?..... Yes No

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

Name of patient: _____	Name of patient: _____
Condition/Illness: _____	Condition/Illness: _____
Dates of treatment: From _____ Through _____	Dates of treatment: From _____ Through _____
Treatment rendered: _____	Treatment rendered: _____
Still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication and dosage taken: _____	Medication and dosage taken: _____
Date: From _____ Through _____	Date: From _____ Through _____
Treating providers, name/address: _____	Treating providers, name/address: _____

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

1. Do any persons on this application intend to continue other Group coverage if this application is issued? Yes No
 If yes, name of person: _____ Insurance Company: _____ Policy No.: _____

2. Has any person applying for coverage had health insurance coverage at any time in the past (12) months? Yes No
 If yes, Proof of Coverage must be submitted. (See 7A.)
 (Any Individual UniCare coverage must be terminated if and when issued by this Group Medical Plan.)
 If yes, Name: _____ Type of coverage: Group Individual Other (specify): _____
 Insurance Co: _____ Date coverage began: _____ Date ended: _____

3. Does any person applying for coverage currently have Dental Insurance coverage? Yes No
 If yes, Type: _____ Insurance Co: _____ Date coverage began: _____ Date ended: _____

7A. PROOF OF PRIOR COVERAGE (Required)

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

Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. copy of 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 pre-existing conditions limitation with no credit for prior coverage. You are entitled to a Certificate of Coverage from your prior carrier. UniCare will assist in obtaining this information on your behalf should the need arise. Pre-existing conditions are 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 9 months for groups with no more than 50 employees, or 12 months for groups with more than 50 employees, and the exclusion is reduced by the aggregate of the periods of prior creditable coverage.

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

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

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

Even if this application is approved, any material misstatements or omissions may result in future claims being denied and the policy or your coverage under the policy being rescinded or re-evaluated, as of the effective date, for eligibility and rating purposes.

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 nonparticipating provider.

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.

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 have 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.

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

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

SIGNATURE OF EMPLOYEE (Required) X	TODAY'S DATE (Required) X	SIGNATURE OF EMPLOYEE'S SPOUSE (Required) X	TODAY'S DATE (Required) X
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MEDICAL PRE-EXISTING CONDITION EXCLUSION NOTICE

This plan imposes a pre-existing 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 pre-existing 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 (or 18 months if you are a late enrollee) for employees of a group of 51 or more eligible employees, or 9 months (or 15 months if you are a late enrollee) for employees of a group with 2 to 50 eligible employees, 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 pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18 months) or 9-month (or 15 months) 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 pre-existing 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 1 (888) 747-4535.