Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: Tel.(818) 654-4548 Fax .(818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana , CA 91356

Please make your check payable to: UniCare

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at: (818) 654-4548

UniCare®

UniCare Life & Health Insurance Company
APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

For Seniors with Medicare Parts A and B

UNICARE
Arizona

Section 1 – Choice of Coverage

Please check the box for your choice of Medicare supplement coverage:

☐ Standard Plan A ☐ Standard Plan F ☐ PrimeChoice℠ Plan (High Deductible Plan F)
☐ PrimeChoice℠ Preferred Plan (High Deductible Plan F)

Section 2 – Applicant Information

This complete original application will be returned to you, for your records, along with your policy when you are enrolled.

Please copy the information from your Medicare card here ⇩

NAME OF BENEFICIARY (Applicant):	CLAIM NUMBER:	SEX:
IS ENTITLED TO:	EFFECTIVE DATE:	
HOSPITAL INSURANCE:		
MEDICAL INSURANCE:		

Requested effective date or end date of prior Medicare supplement, if replacing: _____ /_____ /_____

Name (as it appears on your Medicare card): _____

Social Security Number: |_|_|_|_|_|_|_|_|_| Date of Birth: _____

Home Address, Apt. No., Suite No.: _____

City: _____ County: _____ State: _____ ZIP: _____

Home Telephone Number: _____

Billing Address (if different from home address): _____

City: _____ County: _____ State: _____ ZIP: _____

Care of/Attention: _____

If transferring from another UniCare Group/Individual or UniCare out-of-state plan, indicate:

Group Number: _____ State: _____ Policy Number: |_|_|_|_|_|_|_|_|_|

Section 3 – Billing Information

❑ Annual ❑ Quarterly ❑ Bimonthly ❑ Monthly (Checking Account Deduction Only)

UniCare Use Only

Broker Number:_____ H/S: ☐ Yes ☐ No

Amount Received: $ _____

Group No.: _____ Policy No.: _____ Effective Date: _____

X Re. Cert. No.: _____

Insert check face up. Please submit one month's premium for your Medicare supplement plan, plus an additional one-time non-refundable $5 processing fee.

Please make check or money order for premium payable to UniCare.

Applicant: Please return application to agent or to the mailing address below.

UniCare Life & Health Insurance Company,
Administrative Office, P.O. Box 9063, Oxnard, CA 93031-9063

Section 4 – Health History

THIS SECTION MUST BE COMPLETED BY APPLICANT

Check the box next to any conditions that apply to you.

	Yes	No
1. Are you currently confined or has confinement been recommended to a bed, hospital, nursing facility or other care facility, or do you need the assistance of a wheelchair for any daily activity?	❑	❑
2. Within the past two years, have you been hospitalized two or more times or been confined to a nursing home for a total of two weeks or longer?	❑	❑
3. Within the past two years, have you been advised to have surgery which has not yet been done?	❑	❑
4. Within the past five years, have you been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions:		
a. Heart conditions including but not limited to heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease or stroke?	❑	❑
b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder or other senility disorder?	❑	❑
c. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD) or emphysema (excluding allergies and asthma)?	❑	❑
d. Internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea), amputation or joint replacement due to disease?	❑	❑
5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	❑	❑

List all prescription drugs currently prescribed for your use: (If none, write "none.") _____

_____

List name, address and telephone number of prescribing physician, if different from below: _____

_____

_____

_____

Applicant's Initials: _____

Section 5 – Medical Information

Name of Primary Care Physician: _____ Telephone: (_____)_____

Address: _____

Section 6 – General Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge,

1. a. Did you turn age 65 in the last six months? ❑ Yes ❑ No
   b. Did you enroll in Medicare Part B in the last six months? ❑ Yes ❑ No
   c. If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program? ❑ Yes ❑ No
   [NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]
   If yes,
   a. Will Medicaid pay your premiums for this Medicare supplement policy? ❑ Yes ❑ No
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ Yes ❑ No
3. a. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. _____/_____/_____
   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ❑ Yes ❑ No
   c. Was this your first time in this type of Medicare plan? ❑ Yes ❑ No
   d. Did you drop a Medicare supplement policy to enroll in this Medicare plan? ❑ Yes ❑ No

Optional Monthly Checking Account Deduction 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 Life & Health Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall 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 premiums. This authority is to remain in effect until revoked by me in writing or verbally and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt 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.

Please attach a blank check marked "VOID."

Insured	Social Security Number
	Bank Name
x Date	x Date

Authorized signature(s) as it/they appear in the financial institution's records. All authorized persons must sign.

Section 6 – General Information (continued)

4. a. Do you have another Medicare supplement policy in force? ❑ Yes ❑ No

   b. If so, with what company and what plan do you have? _____

   c. If so, do you intend to replace your current Medicare supplement policy with this policy? ❑ Yes ❑ No

5. Have you had coverage under any other health insurance within the past 63 days? ❑ Yes ❑ No
   (For example, an employer, union, or individual plan.)

   a. If so, with what company and what kind of policy? _____

   _____

   b. If so, with what company and what plan do you have? _____

   c. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank. _____/_____/_____

Section 7 – Conditions of Application

Please read the following carefully.

1. I agree to pay an application fee equal to the premiums required for the plan requested on this application, that this payment will be returned to me if my application is rejected or will be applied to the premiums if my application is accepted.
2. UniCare will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B. If my application is not received during the open enrollment period, UniCare has the right to reject my application. If UniCare rejects my application, I will be notified in writing and any application fees submitted with this application will be refunded. I understand and agree that if UniCare rejects my application, under no circumstances will any UniCare benefits be payable. **Cashing of my check by UniCare does not constitute approval of my application.**
3. If my application is accepted, this application will become part of the agreement between UniCare and myself.
4. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policies or terms of any UniCare coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that UniCare may void all coverage from the original effective date of the policy for material misstatements or omissions.

Notice to Applicant

- **You do not need more than one Medicare supplement policy.**
- **If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.**

PRIORITY PROCESSING

Complete the other side of this form to enroll in the Optional Monthly Checking Account Deduction Authorization.

Include a blank check marked "VOID." Please do not submit a deposit slip.

Section 7 – Conditions of Application (continued)

- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended if requested while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Section 8 – Authorization and Agreements

CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS

Name	ID Number	Phone

Address (Street, City, State, ZIP)

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: The United States Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other healthcare professional, hospital or other healthcare facility, counselor, therapist or any other medical or medically-related facility or professional.

Entities or Persons Authorized to Receive: UniCare Life & Health Insurance Company or affiliate ("UniCare"), its agents, employees, designees or representatives, including my UniCare agent or broker.

Purpose of this Authorization: By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Section 8 – Authorization and Agreements (continued)

Obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

Effect of Declining: If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you the benefits. This PHI used or disclosed may be subject to redisclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

This authorization is a condition of our paying the claim. If you decide not to sign this authorization, we may decline to pay the claim.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to redisclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon the termination of any UniCare coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

UniCare, PO. Box 9063
Oxnard, CA 93031-9063
Telephone 800-508-9355, Fax 805-375-0361

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization and I understand that by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization. This authorization will be valid for a period not to exceed 24 months from the date of application.

x _____ x _____ _____

Print Name | **Applicant's Signature** | **Date**

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

_____ _____

Personal Representative: Print Name | **Relationship to Individual**

x _____ _____

Applicant's Signature | **Date**

A photocopy of this authorization is as valid as the original and my UniCare agent or broker and I are entitled to receive a copy of this form. YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

■ I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare" and "Outline of Medicare Supplement Coverage and Premium Information" as required. I understand that receipt of money with this application does not create UniCare Life & Health Insurance Company coverage. Coverage will come into effect only if this application is approved by UniCare Life & Health Insurance Company.

■ The undersigned applicant and the agent certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

x _____ _____

Applicant's Signature | **Date of Signature**

x _____ _____

Agent's Signature | **Date of Signature**

For Agent Only

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date:

From: _____
Mo./Yr.

To: _____
Mo./Yr.

Name of Policy:

_____

Name and Address of Insurance Company:

Name: _____

Address: _____

City/State: _____

(Attach additional sheets, if necessary.)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," an outline of coverage for the policy applied for and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

Agent's Signature Oleg Skurskiy Date of Signature (City and State) B C L N G N P V M Z

Print Agent's Name 18375 Ventura Blvd. # 226 (818)654-4548 Agent No.

Street Address Tarzana ,CA 91356 Telephone No.

City State ZIP

Premium Amount: $_____

Send Policy and ID Card To: ❑ Agent XX ❑ Insured

The ID card will be sent to the insured in a separate mailing.

Receipt for cash received

Date: _____ Amount: _____

Name: _____

Social Security Number: _____

Account: _____ Check Number: _____

Policy Description: _____

Received By: _____

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.