



Short-Term Enrollment Application – Texas

1. Please print in blue or black ink.
2. Complete both sides of this application.
3. Send completed application and payment in full to UNICARE Life & Health Insurance Company. (See Section 7).

RUSH

1. Applicant Information

Primary Applicant's Last Name		First Name		M.I.	Primary Applicant's Social Security No.	
Street Address (Must be completed: P.O. Box not acceptable)					Home Phone No. ()	
City		State		ZIP Code	Daytime Phone No. ()	
County Applicant Resides in (Required)					Fax No. ()	
Mailing Address (If different than above) or P.O. Box			City		State	ZIP Code
E-mail Address				If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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)		4 <input type="checkbox"/> Asian		A <input type="checkbox"/> Amerasian	K <input type="checkbox"/> Korean	R <input type="checkbox"/> Guamanian
1 <input type="checkbox"/> Caucasian		5a <input type="checkbox"/> Native American Indian		C <input type="checkbox"/> Chinese	M <input type="checkbox"/> Samoan	T <input type="checkbox"/> Laotian
2 <input type="checkbox"/> Hispanic		5b <input type="checkbox"/> Alaskan Native		H <input type="checkbox"/> Cambodian	N <input type="checkbox"/> Asian Indian	V <input type="checkbox"/> Vietnamese
3 <input type="checkbox"/> Black/African American		7 <input type="checkbox"/> Filipino		J <input type="checkbox"/> Japanese	P <input type="checkbox"/> Hawaiian	Z <input type="checkbox"/> Other

2. Plan Selections

A. Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000			
B. Policy Term: No. of Days _____ (minimum of 30 up to a maximum of 180 days)			

3. Effective Date

▶ If you are approved, coverage automatically begins at 12:01 a.m. on the date following the postmark date stamped on the envelope, or date received by UNICARE.
If application is faxed or submitted online, coverage begins the day after application is received.

▶ Or coverage (upon approval) may begin on a specific future date within 30 days of signature.
(Please specify) _____ (Mo/Day/Yr). Postmark date must precede requested effective date. **Exceptions are not permitted.**

4. 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 the application.

Newborn children under 15 days of age are not eligible for coverage.

Sex	Last Name	First Name	M.I.	Social Security No.	Date of Birth (Mo/Day/Yr)
<input type="checkbox"/> M <input type="checkbox"/> F	Applicant				
<input type="checkbox"/> M <input type="checkbox"/> F	Spouse				
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent				
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent				
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent				

Insurance coverage underwritten by UNICARE Life & Health Insurance Company, a separately capitalized and incorporated subsidiary of WellPoint Health Networks Inc. ® Registered Mark of WellPoint Health Networks Inc.

TXIMSTAP0902

5. Application Questions Answer the following questions completely and accurately.

Note: If the answer to any question below is YES, the policy cannot be issued.

<p>1. Has any person applying for coverage resided outside the United States continuously for the past 6 months without current U.S. citizenship or permanent U.S. residency? ... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you or any person applying have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to the effective date of this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, when will existing coverage expire? (Mo/Day/Yr) _____</p> <p>3. (a) 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (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 the application?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you or any person applying received any medical or surgical consultation, advice or treatment, including medication, within the past 10 years for: heart or circulatory system disorder including heart attack or chest pain; stroke; disorders of the blood, including hemophilia and leukemia; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency; immune disorders; organ transplant; kidney or liver disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>5. Has any person listed on this application been diagnosed as having or received treatment by a physician or health care professional for hepatitis, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you, or any person applying, enrolled in training for or engaged in an occupation involving unusual hazards, and not covered by Workers' Compensation Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. In the past 12 months, have you or any person to be insured been recommended by a physician or health care professional to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered YES to any question from 1-7, please complete this section.</p> <p>Person(s) listed below are excluded from coverage.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Question No.</th> <th>Person(s) to whom it applies</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Question No.	Person(s) to whom it applies						
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6. Other Coverage Please answer **all** of the following questions

A. Do you currently have, or has anyone to be insured had coverage in the last 18 months? Yes No
If yes, please provide the following information.

Name of insured	Health Benefit Plan(s)	Effective date	End date
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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

To provide further information, please use additional sheets if necessary. List the 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

7. Payment Method

Premium must be paid in full and submitted with application. Payment will be held in trust while this application is evaluated.

	x		=	
Amount of premium (per day rate)		no. of days		premium

Payment by Credit Card

Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	Card No.	Expiration Date
Cardholder's Name	Relationship to Applicant	Signature of Authorized Cardholder X
Date		

If paying by credit card, you may fax applications to UNICARE AT 1-630-679-4081.

Payment by Check

Mail application with a check for premium (payable to UNICARE Life & Health Insurance Company) to:
UNICARE Life & Health Insurance Company • P.O. Box 5058 • Bolingbrook, IL 60440-5058

8. To be completed by your UNICARE-Appointed Agent

1. 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? Yes No
2. Did you see the proposed insured (and spouse, if applying) at the time this application was executed? Yes No
3. Total funds collected: \$ _____
 (Premium must be paid in full and submitted with application.)

Name of Writing Agent (Print name)		Agent's Street Address		Suite	No./Personal Mail Box(PMB) No.	
Agent/Agency I.D. No.	Sub-Agent I.D. No.	City		State	ZIP Code	Location No.
Phone No.	Fax No.	E-mail Address				
Signature of Writing Agent (Required)		Date (Required)				

Mail Service Agreement to: Agent Primary Applicant
 PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the primary applicant's mailing address:
 Agent: Please mail this application to the following address:
UNICARE Life & Health Insurance Company • P.O. Box 5058 • Bolingbrook, IL 60440-5058

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UNICARE Life & Health Insurance Company
Short Term Conditional Receipt and Special Instruction
 (To be completed by the agent and given to the applicant)
For information on eligibility, please call 800-718-9355

Received from _____ \$ _____ as the full premium payment for the Short Term
 Policy purchased for a period of _____ days, payable to UNICARE Life & Health Insurance Company.

(over)

9. Application Conditions and Agreement IMPORTANT: It is important that you carefully read and fully understand the following.

AUTHORIZATION

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 for a period not longer than two (2) years. 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. I understand that coverage is subject to the provisions in the Conditional Receipt. I have read and understand this Application in its entirety. I have received a written plan description.

AGREEMENT (all applicants)

I, the undersigned, agree to the following:

- a. I understand and agree to pay the premium amount required with this application. If my application is denied, UNICARE will return the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.
- b. UNICARE may decline my application. No coverage comes into effect until UNICARE approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be indicated on the identification card and/or assigned by UNICARE at its discretion.
- c. **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.
- d. **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 Section 5 with them, and (3) all information contained in this application regarding them is complete and accurate.
- e. 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 premium check or charging either of these amounts to my credit card by UNICARE does not constitute approval of my application or create UNICARE coverage.
- f. If I am accepted, this application will become part of the agreement between UNICARE and myself.

- g. I understand UNICARE Life & Health Insurance Company may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.
- h. The selling agent has no authority to promise me coverage or to modify UNICARE underwriting policy or terms of any UNICARE coverage.
- i. 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 on this application.
- j. My UNICARE agent may receive copies of any correspondence about my medical history when correspondence is required.
- k. I understand that a Short Term Plan is not a group plan and therefore, coverage under a Short Term Plan may make a person ineligible for HIPAA.

Signatures (Required)

IMPORTANT: All applicants over age 18 must sign and date.

Applicant/Parent or Legal Guardian X	Today's Date
Applicant's Spouse X	Today's Date
Applicant age 18 or over X	Today's Date
Applicant age 18 or over X	Today's Date
For UNICARE use only - Do not write below	
Effective Date	End Date

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This amount is tendered with the application for the referenced Plan as a deposit against the premium due, subject to the following: **IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT ACCEPTED BY UNICARE AT ITS HOME OFFICE, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THE APPLICATION IS APPROVED BY UNICARE AND THE PAYMENT IS MADE. If the application is accepted, the applicant shall be advised in writing by UNICARE. If the application is not accepted, UNICARE will advise the applicant and promptly refund the premium deposit paid; and refund of such deposit will fully discharge any and all obligations of UNICARE to the applicant.**

Dated this _____ day of _____, Agent acknowledges receipt of money and delivery of conditional Receipt.

By: _____
Signature of Agent Agent ID 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.