UniCare

SHORT-TERM ENROLLMENT APPLICATION – ILLINOIS

UniCare Health Insurance Company of the Midwest

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 Health Insurance Company of the Midwest. (See Section 7.)

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? ☐ Yes ☐ No

Language preference (Optional) ☐ English ☐ Spanish ☐ Korean ☐ Chinese ☐ Polish ☐ Other (Specify):

Ethnic Code *(Optional)*

1 ☐ Caucasian	4 ☐ Asian	A ☐ Amerasian	K ☐ Korean	R ☐ Guamanian
2 ☐ Hispanic	5a ☐ Native American Indian	C ☐ Chinese	M ☐ Samoan	T ☐ Laotian
3 ☐ Black/African American	5b ☐ Alaskan Native	H ☐ Cambodian	N ☐ Asian Indian	V ☐ Vietnamese
	7 ☐ Filipino	J ☐ Japanese	P ☐ Hawaiian	Z ☐ Other

2. Plan Selections

A. Deductible: ☐ **$250** ☐ **$500** ☐ **$1,000** ☐ **$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, unless you specified a later date in which event your coverage will begin on the date specified. If the application is faxed or submitted online, and you are approved, coverage begins the date after the application is received unless you specified a later date in which event your coverage will begin on the date specified.

▶ 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.
Dependents between the ages of 19 through 22 are eligible as dependents only if they are claimed on your Federal Income Tax.

Sex	Last Name	First Name	M.I.	Social Security No.	✓ Full Time Student	Date of Birth (Mo/Day/Yr)
☐ M ☐ F	Applicant					
☐ M ☐ F	Spouse					
☐ M ☐ F	Dependent					
☐ M ☐ F	Dependent					
☐ M ☐ F	Dependent					

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.

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? ☐ Yes ☐ No

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 or on the effective date of this coverage? ☐ Yes ☐ No

   If YES, when will existing coverage expire?) (Mo/Day/Yr)_____

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? ☐ Yes ☐ 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? ☐ Yes ☐ No

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; hypertension; 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? ☐ Yes ☐ No

5. Has any person listed on this application ever been diagnosed 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)? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If you answered YES to any question from 1-7, please complete this section.

Person(s) listed below are excluded from coverage.

Question No.	Person(s) to whom it applies

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	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**

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.

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

7A. ☐ Payment by Credit Card

Credit Card ☐ VISA ☐ MasterCard ☐ 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 (630) 679-4081.

7B. ☐ Payment by Electronic Check

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. I further agree that if any such debits 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.

Name on Account	Check No.	Premium Amount $	Checking Account No.
Bank Routing No.		Account Type ☐ Personal ☐ Business	
Relationship to Applicant		Signature of Authorized Account holder X	Date

If paying by electronic check, you may fax applications to UniCare at (630) 679-4081.

7C. ☐ Payment by Check

When you send your check to us, you authorize UniCare to convert your check into an electronic fund transfer. If you are approved for coverage and the policy is issued, your bank account will be debited for the amount indicated on the check, no refunds are permitted. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you. Mail application with a check for premium (payable to UniCare Health Insurance Company of the Midwest) to:

UniCare Health Insurance Company of the Midwest • P.O. Box 5058 • Bolingbrook, IL 60440-5058

8. Conditional Receipt

UniCare Health Insurance Company of the Midwest
Short Term Conditional Receipt and Special Instruction
(To be completed by the agent and given to the applicant, if applicable.)
For information on eligibility, please call (800) 379-0274

Received from _____ $_____ as the full premium payment for the Short-Term

Policy purchased for a period of _____ days, payable to UniCare Health Insurance Company of the Midwest.

(over)

9. 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.			
OLEG SKURSKIY		18375 VENTURA BLVD #226,			
Agent/Agency I.D. No.	Sub-Agent I.D. No. BCLNGNPVMZ	City TARZANA	State CA	ZIP Code 91356	Location No.
Phone No. 818- 9875000	Fax No. 818- 7769865	E-mail Address oleg@askoleg.com			
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 Health Insurance Company of the Midwest • P.O. Box 5058 • Bolingbrook, IL 60440-5058

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

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 not submit my check for a funds transfer. If my application is accepted, this premium amount will be applied to the premium charges.

b. If my application for UniCare coverage is accepted as applied for, the coverage date will become effective as noted in section 3.

c. 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.

d. **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.

e. **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.

f. 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, by UniCare does not constitute approval of my application or create UniCare coverage.

g. I understand UniCare 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. If I am accepted, this application will become part of the agreement between UniCare and myself.

i. 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.

j. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.

k. 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 Section 5 and sign the Authorization in Section 10 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.

l. My UniCare agent may receive copies of any correspondence about my medical history when correspondence is required.

m. I understand that a Short Term Policy is not a group plan and therefore, coverage under a Short Term Policy may make a person ineligible for HIPAA.

7378IL 1/05 04

This amount is tendered with the application for the referenced Policy 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 PREMIUM 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.

10. Application Conditions and Agreement (continued)

Authorization

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, 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 does 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 has 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 and agree to all Application Conditions (Section 10). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 8). I have read and understand the above disclosure statement. I have read and understand this Application in its entirety.

Signatures *(Required)*
IMPORTANT: All applicants over age 18 must sign and date.

Applicant/Parent or Legal Guardian	Today's Date
X	
Applicant's Spouse	Today's Date
X	
Applicant age 18 or over	Today's Date
X	
Applicant age 18 or over	Today's Date
X	

For UniCare use only - Do not write below	
Effective Date	End Date