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: (818) 987-5000 (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) 987-5000

VIRGINIA

UniCare®

INDIVIDUAL & FAMILY PPO HEALTH INSURANCE PLANS

UniCare Premier No Deductible Plan
UniCare 500, 1000, 1500, 2000, 3000, 5000 Plans
UniCare Saver Plan
UniCare High-Deductible (HSA-Compatible) Plans

LIFE AND DENTAL PLANS – APPLICATION

Thank you for applying with UniCare.

PLEASE NOTE:

– Coverage is not available if:

- any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
- the applicant has not resided in the U.S. for the last six (6) consecutive months.

– Coverage is not guaranteed until approved in writing by UniCare. Do not cancel your current insurance coverage until you have been notified of approval by UniCare and your UniCare coverage is effective.

Instructions

Do not complete this application until you have read the current product brochure.

Please follow these instructions to allow us to better process your application.

– For your own protection, **you, the applicant,** must complete this application. You are solely responsible for its accuracy and completeness.

– All information must be stated accurately.

– All questions must be answered in full or the application may be returned to you resulting in a delay in processing.

– For additional information or explanations attach extra sheets, if necessary. **All attachments must be signed and dated.**

– Print clearly using blue or black ink. No correction fluid, please. **Sorry, but typed applications will not be accepted.**

– This application must be received by UniCare Medical Underwriting within thirty (30) days from the signature date.

– UniCare Health and Dental Plans are available only in areas where the UniCare Network exists. Please see Provider Directories for more details.

– Even if this application is approved, any misstatements or omissions may result in future claims being denied and the plan being rescinded.

– Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Section 7 – Conditions of Application).**

– Please return this application and your check to your agent OR mail to the address listed at right.

Billing Information

Carefully read the instructions accompanying each billing type and make sure that your check is attached to the application.

– Monthly billing (with monthly bank draft authorization only): Submit the one (1)-month premium, complete the Monthly Bank Draft Authorization.

– Quarterly billing: Submit the three (3)-month (quarterly) premium.

Most common causes for delay in underwriting

– Missing, inaccurate or incomplete information such as:

- Weight AND Height
- Spouse's social security number
- Dependent's social security number
- Date of birth
- Date of last pelvic examination
- Results of last pelvic examination
- Physician address, phone number and fax number

– Incomplete or illegible information such as the mailing address does not include city, state, and ZIP code.

– ALL questions are not answered in Sections 4 and 6. If it does not apply to you, the answer should be "No." Do not leave any answers blank.

– The application is not signed and dated by the applicant and/or all dependents over age 18.

– Agent portion of application is not completed, signed, or dated with a date on or after applicant's signature date.

– Additional documentation or information is required.

Mailing Address

– Applicant: Please return this application to the agent.

– Agent: Please mail this application to the address below.

UniCare Life & Health Insurance Company
Attn: UniCare Individual Services – Virginia
P.O. Box 5030
Bolingbrook, IL 60440-5030

Insurance coverage underwritten by UniCare Life & Health Insurance Company. ® Registered Mark of WellPoint, Inc. 0010117VA 6/05

UNICARE

UniCare Life & Health Insurance Company

Applicant's Social Security No.

INDIVIDUAL ENROLLMENT APPLICATION - VIRGINIA

- Application must be completed by the applicant in blue or black ink.
- Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.

1. Applicant Information *(Please Print)*

Primary Applicant's Last Name	First Name	M.I.
Home Address *(Residence address required; P.O. Box not acceptable)*		
City	State	ZIP Code

Reason for Application *(Check one)*

☐ New Enrollment(s)
☐ Child only *(Please use youngest child for primary applicant)*
☐ Add dependent(s) to I.D. No: _____
To change existing UniCare plan, please enter I.D. No: _____
For Summary Bill (existing), I.D. No: _____

Mailing Address *(If different than above)* (P.O. Box or Personal Mail Box No.)		Home Phone No. ( )	E-mail Address *(Optional)*
City	State ZIP Code	Daytime Phone No. ( )	Fax No. ( )
In care of:		Marital Status ☐ Single ☐ Married	Spouse's Social Security No. *(Required)*
Billing Type: ☐ Monthly Bank Draft ☐ Quarterly Billing ☐ Summary Bill *(Please attach Summary Bill cover sheet.)*		Maiden Name of Applicant / Spouse *(If applicable)*	

Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? ☐ Yes ☐ No
If yes, please provide name and explain:

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

Ethnic Code (Optional)

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

2. Choice of UniCare Individual Coverage

☐ UniCare Saver 2000 (G865) ☐ UniCare1500 (G863) ☐ HSA-Compatible Variable-Deductible Plan (T781) ☐ High-Deductible Single $2,500 Plan (H044)
☐ UniCare 5000 (PE35) ☐ UniCare 1000 (G862) ☐ HSA-Compatible ($2,600/$5,200) Plan 2 (T089) ☐ High-Deductible Family $4,950 Plan (H045)
☐ UniCare 3000 (PE34) ☐ UniCare 500 (G861) ☐ HSA-Compatible Variable Contribution Plan (X443) ☐ Life ☐ Dental
☐ UniCare 2000 (G864) ☐ Premier No Deductible Plan (G860) ☐ HSA-Compatible ($5,000/$10,000) Plan 3 (T090)

3. 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 application.

Relation	Last Name First Name M.I.	MUST BE ACCURATE Height	MUST BE ACCURATE Weight	Date of Birth	Social Security No.	✓ Full Time Student	FamilyFlex® List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY WVR	UNICARE USE ONLY WVR
☐ Male ☐ Female	Yourself									
☐ Husband ☐ Wife	Spouse									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

FOR UNICARE USE ONLY – DO NOT WRITE BELOW

Group No.	Certificate No.	Agent I.D. No.	Effective Date	X Ref. Cert. No.	☐ AA ☐ AR
By	Date				

Applicant's Social Security No. | | | | | | | | | |

4. Other Coverage - *Please answer **all** of the following questions.*

A. Do you currently have, or has anyone to be insured had continuous coverage in the last 18 months? . . . . . ☐ Yes ☐ No
Was the coverage a ☐ Group or ☐ Individual or ☐ government or ☐ church sponsored health plan?
Did this coverage end within the last 63 days for a reason other than fraud or non-payment of premium? ☐ Yes ☐ No

B. Have you had a minimum of 12 months of continuous Individual coverage that was terminated due to non-renewal of your health plan that ended within the last 63 days? . . . . . ☐ Yes ☐ No

If Yes to A or B, please provide the following information. *Please attach the Certificate of Creditable Coverage from your prior health insurance carrier.*

Name of Insured(s)	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:

C. Are/will/were you or anyone to be insured eligible for COBRA or any state continuation of coverage plan? . . . . . ☐ Yes ☐ No
If Yes, effective date _____ End date _____

D. 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(s)	Plan/I.D. No.	Group No.	
Name of Plan	City	State	Date cancelled

E. If any applicant has/had UniCare group coverage, please complete the following:

I certify that my UniCare group coverage will end/ended on (date):

☐ **I do not wish to enroll in any available Conversion Agreement.** I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.

F. Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? . . . . . ☐ Yes ☐ No
If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain

G. Are any persons applying for coverage on this application eligible for
☐ 1 Medicare ☐ 2 Medicaid ☐ 3 Employer-sponsored health benefits? . . . . . ☐ Yes ☐ No
If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.

Eligible person(s) and corresponding box number(s)

H. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? . . . . . ☐ Yes ☐ No
If Yes, please provide the following information.

Name of applicant	Effective date	End date

5. Term Life Insurance

Applicants must meet UniCare's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. **Submit Premium with application.**

Name of Family Member	✓ Amount of Coverage			Name of Beneficiary**	Relationship	Beneficiary Street Address City / State / ZIP Code
	$15,000	$25,000	$50,000*			
Primary Applicant						
Spouse						
Dependent						

*The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.
****If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

I have discussed Life Insurance with my agent and decline to apply – Initial: _____

Applicant's Social Security No.

6. Health History – Include information on *all* family members you wish to enroll.

6A. Health History Questionnaire – *ALL* QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.

Has any person listed on this application had a clear, distinct symptom that would cause an ordinarily prudent person to seek advice or treatment, or had treatment recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **within the last 10 years:**

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis, or any other neurological or central nervous system disorder(s) ☐ Yes ☐ No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy, or any similar symptoms ☐ Yes ☐ No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition ☐ Yes ☐ No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, or any other circulatory condition ☐ Yes ☐ No
5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, reactive airway disease (RAD), pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition ☐ Yes ☐ No
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, or use of a sleep monitoring device ☐ Yes ☐ No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ ☐ Yes ☐ No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, or any other digestive disorder or condition ☐ Yes ☐ No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain, or hepatitis (indicate type:_____) ☐ Yes ☐ No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system ☐ Yes ☐ No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio, or any other musculoskeletal disorder ☐ Yes ☐ No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation, or prosthesis ☐ Yes ☐ No
13. Diabetes, thyroid, pituitary, adrenal, or any other endocrine disorders ☐ Yes ☐ No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome ☐ Yes ☐ No
15. Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? ☐ Yes ☐ No
16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery, or any other skin conditions ☐ Yes ☐ No
17. Sexually transmitted disease, such as herpes, genital warts, etc. ☐ Yes ☐ No
18. Male applicant(s)
    a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, or implant ☐ 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 this application? ☐ Yes ☐ No
19. Female applicant(s)
    a) Breast disorder/cyst, lump, fibroid tumors, silicone injections, or implants ☐ Yes ☐ No
    b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages ☐ Yes ☐ No
    c) Date and result of last pelvic exam/Pap smear for each female over 16:
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    Name:_____ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    d) 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
20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision ☐ Yes ☐ No
21. Diseases or problems of the ears or hearing, implant, or hearing aid ☐ Yes ☐ No
22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. ☐ Yes ☐ No
23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify:_____ ☐ Yes ☐ No
24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? ☐ Yes ☐ No

Has any person listed on this application **ever**:

25. Had cancer, tumor/growth, leukemia, or cyst? ☐ Yes ☐ No
26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery, or treatment? ☐ Yes ☐ No
27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor, or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? ☐ Yes ☐ No
28. Been diagnosed or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? ☐ Yes ☐ No

IMPORTANT: ***Applicant's medical conditions, which occur after the signature date and before the approval date that come to UniCare's attention, may be considered in the final underwriting decision.***

6B. Professional Services

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Applicant's Social Security No.

Question # Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility		Date of Visit
Name of Condition/Illness	Date Ended	Address		Phone No.
Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State ZIP	Fax No.
Results ☐ Normal ☐ Abnormal ☐ Still under treatment		Medications		Frequency
If abnormal, please explain:		Dosage	Date Prescribed	Date Discontinued

Question # Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility		Date of Visit
Name of Condition/Illness	Date Ended	Address		Phone No.
Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State ZIP	Fax No.
Results ☐ Normal ☐ Abnormal ☐ Still under treatment		Medications		Frequency
If abnormal, please explain:		Dosage	Date Prescribed	Date Discontinued

Question # Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility		Date of Visit
Name of Condition/Illness	Date Ended	Address		Phone No.
Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State ZIP	Fax No.
Results ☐ Normal ☐ Abnormal ☐ Still under treatment		Medications		Frequency
If abnormal, please explain:		Dosage	Date Prescribed	Date Discontinued

6C. Prescription Medications –

List all medications not noted above taken within the last 12 months by any family member listed on this application.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued	Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/ZIP Code

6D. Other Health Questions

1. Has any applicant ever smoked or used any tobacco products, such as: cigarettes, cigars, pipe, snuff, or chewing tobacco? ☐ Yes ☐ No	1. Family member	Amount per day	2. Family member	Amount per day
	Type of product	Date Discontinued	Type of product	Date Discontinued
2. Has any applicant used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, in the last 10 years, or been diagnosed as chemically or alcohol dependent? ☐ Yes ☐ No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant ever used any illegal or controlled I.V. drugs? ☐ Yes ☐ No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has any applicant consumed any alcoholic beverages in the last 6 months? ☐ Yes ☐ No	1. Family member		2. Family member	
Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	Amount ________ per ☐ day ☐ week ☐ month		Amount ________ per ☐ day ☐ week ☐ month	
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? ☐ Yes ☐ No	1. Family member	Date Discontinued	2. Family member	Date Discontinued

To provide further information, please use additional sheets if necessary. List the page number, 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. Conditions of Application

It is important that you carefully read and fully understand the following.

Applicant's Social Security No.

I, the undersigned, understand that under the UniCare plan for which I am applying, I may be entitled to lesser benefits if I use a non-participating hospital, physician, or other provider, than if I use a UniCare independently contracted participating hospital, physician, or other provider.

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section 11, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If, however, you would like to request a specific effective date, we strongly recommend you allow 60-75 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance, and will prevent you from being required to pay for two policies.

NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.

☐ I request that UniCare assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.

☐ If UniCare approves my application, please assign an effective date of the

- ☐ 1st of the month following approval.
- ☐ 15th of the month following approval.
- ☐ 1st of _____.
- ☐ 15th of _____.

This date must be AFTER the signature date but not greater than 75 days from the signature date on this application.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE CERTIFICATE OF COVERAGE IS ISSUED. Initial X_____

Billing Date

UniCare premiums are due on the 1st of each month. Insureds with a mid-month premium effective date will be billed on a pro-rated basis to bring future due dates to the first of a month.

Agreement *(All applicants)*

I, the undersigned, agree to the following:

1. I understand and agree to pay the premium required with this application. This payment is a deposit which will be returned if my application is denied, or applied to the premium charges if my application is accepted.
2. If my application for UniCare coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by UniCare that my application is approved.
3. 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.
4. **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.
5. **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 Sections 6A, 6B, 6C and 6D with them, and (3) all information contained in this application regarding them is complete and accurate.
6. 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 check or charging my credit card by UniCare does not constitute approval of my application or create UniCare coverage.
7. If I am accepted, this application will become part of the agreement between UniCare and myself.
8. 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.
9. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.
10. 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 the Health History Section and sign the Conditions of Application 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.
11. My UniCare agent may receive copies of any correspondence about my medical history when correspondence is required.

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 the Conditions of Application (Section 7). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 12). I have read and understand this Application in its entirety.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse *(required if applying for coverage)*	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

ATTACH INITIAL PREMIUM CHECK HERE. DO NOT TAPE.

Applicant's Social Security No.

8. Payment Method – Submit premium payment with application *(required).*

8A. Initial Premium Payment by Credit Card

New members only. Not available to make a coverage change.

Select one: ☐ 1 month ☐ 3 months	Initial Premium Amount $
Credit Card: ☐ VISA ☐ MasterCard	
Credit Card No.	Expiration Date
Cardholder's Name	Cardholder's ZIP Code
Authorized Signature *(as it appears on the credit card)* X	Today's Date

8B. Payment Type

☐ **Monthly Billing** *(Available with Monthly Checking Account Deduction).*

1. Submit the one (1) month premium.
2. Complete section 8C, **Monthly Checking Account Deduction Authorization**.
3. If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account on the first of the month ONLY.

☐ **Quarterly Billing** – Submit the three (3)-month premium.

Please note: First payment will be credited to approved applicants only.

8C. Monthly Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated. If the account listed below is a joint account, both account holders' signatures are required. **UniCare must be notified of any changes to your bank account no later than the 20th of the month preceding the change.**

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 provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights with respect to each debit will 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 premium. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit 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.

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

You will incur a $25 service charge for any withdrawal not honored.

Applicant Name	Applicant Social Security No.	Name on Checking Account		
Name of Bank or Financial Institution	Address	City	State	ZIP Code
Checking Account No.	Bank Routing No.	Federal Credit Union Routing No.		
Authorized Signature *(as it appears in the financial institution's records)*	Date	Authorized Signature *(as it appears in the financial institution's records)*	Date	

(Continued on reverse)

DO NOT WRITE BELOW

Applicant's Social Security No.

9. Are you applying for UniCare medical coverage through a UniCare-appointed agent? ☐Yes ☐No

10. To be completed by your UniCare-Appointed Agent

- ■ 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
- ■ Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? . . . . . ☐ Yes ☐ No

  If no, please explain:

  _____

  _____
- ■ I verify that this application was completed by the applicant unless the Statement of Accountability (Section 11) was completed. . . . . ☐ Yes ☐ No

- ■ Breakdown of premium collected:

  Total Medical premium $ _____

  Total Dental premium $ _____

  Total Life premium $ _____

  Total premium collected **$** _____
- ■ Was the Monthly Checking Account Deduction Authorization (Section 8C) completed? *(only if applicable)*. . . . . ☐ Yes ☐ No
- ■ Was a Conditional Receipt given? . . . . . ☐ Yes ☐ No

Name of Writing Agent *(Print Name)*		Agent's Street Address/Suite or Personal Mail Box No.	
OLEG SKURSKIY		18375 VENTURA BLVD #226,	
Agent/Agency I.D. No.	Sub-Agent I.D. No. BCLNGNPVMZ	City/State/ZIP Code TARZANA, CA 91356	Location No.
Phone No. (818-) 9875000	Fax No. (818-) 7769865	E-mail Address oleg@askoleg.com	
Signature of Writing Agent *(Required)*	Date *(Required)*	RSM Name	

Mail Plan to: ☐ **Agent** ☐ **Primary Applicant**
PLEASE NOTE: If neither box is checked, the Plan will be mailed directly to the primary applicant.
Mailing address: Agent, please mail this application to: **UniCare, P.O. Box 5030, Bolingbrook, IL 60440-5030**

11. Statement of Accountability – To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English
☐ Other *(explain)*: _____

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Application (Section 7)."

By _____ _____
Signature of Translator Today's Date *(Required)*

12. Conditional Receipt – To be completed by the agent and given to the applicant.

Received from _____ $ _____ as a premium amount, payable to UniCare.

Subject to the following:

IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE MONEY SUBMITTED WITH THIS APPLICATION IF THIS APPLICATION IS NOT APPROVED, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THIS APPLICATION IS APPROVED BY UNICARE.

Dated this _____ **day of** _____ **, 20** _____**.**

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By X_____ _____
Signature of Agent Agent I.D. 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.