

**Please call and allow us to assist you with your application**

**713 785-2138**

Avoid headaches and delays by allowing our office to assist you. You'll be surprised at how easy completing an application can be! Once your application is complete, please mail it to:

**Echoicehealthinsurance.com  
8811 Westheimer Ste 207  
Houston, TX 77063**

You may fax your application to: 713 785-2711

Thank you!

# INDIVIDUAL & FAMILY PPO HEALTH INSURANCE PLANS, LIFE AND DENTAL PLANS APPLICATION

## Thank you for applying with UniCare.

If you are electing a UniCare Consumer Choice PPO plan, please note: You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy. Texas regulations requires that you complete and submit a Consumer Choice Disclosure Notice at the time of application and annually, thereafter.

### Please note:

- **Tobacco users and applicants with certain medical conditions pay an additional premium.** For family applications, if any family member who is to be insured smokes or uses tobacco, or has a certain medical condition (“rated person(s)”), an additional premium will be applied to the rated person(s) and the entire family. To avoid the additional premium being applied to the remaining family members, you will have the option to have the rated person(s) placed on a different policy so that he or she is billed separately from the other family members. See details under “Family Split Application Option” in Section 7.
- **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 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) unless you are completing online in which case we will accept a typed application.
- 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 intentional 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 choice of payment method to your agent, submit online OR mail to the address listed below.
- **Also please include a separate \$25 nonrefundable application fee.** Only one application fee is required for families submitting more than one application at the same time in the same envelope. The application fee is waived for applications submitted online, through a UniCare-supported online process.

## **Billing Information**

**Carefully read the instructions accompanying each billing type and make sure that your payment is submitted with the application.**

- **Monthly billing (with monthly bank draft authorization only):** Submit the one month premium; complete the Monthly Bank Draft Authorization.
- **Quarterly billing:** Submit the three 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.
- Failure to include a **separate** \$25 nonrefundable application fee payment.

## **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: Individual Services - Texas**

**P.O. Box 5030**

**Bolingbrook, IL 60440-5030**

**Or for overnight delivery:**

**UniCare**

**Attention -**

**Individual Medical Underwriting Department**

**233 S. Wacker Drive, Suite 3900**

**Chicago, IL 60606-6309**

- **Also available for online submission at [www.unicare.com](http://www.unicare.com)**



UniCare Life & Health Insurance Company

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

# INDIVIDUAL ENROLLMENT APPLICATION - TEXAS

- Application must be completed by the applicant in blue or black ink.
- Any family member currently pregnant or expecting a child (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 from above)<br>(P.O. Box or Personal Mail Box No.)  |  | Home Phone No.<br>( )   | Best Time To Call:                             |
| City  | State  | ZIP Code  | Fax No.<br>( )                                 |
| In care of: (If applicable)   |  | Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married                          | Spouse's Social Security No.<br>(Required)<br> |
| Employer  |  | Maiden Name of Applicant/ Spouse (If applicable)  |  |
| Occupation  | Title  | Business Phone<br>( )   |  |
| E-mail Address (Optional)   |  | If possible do you want e-mail notification? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Have all applicants resided in the U.S. for the past six consecutive months? .....  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| If no, please provide name and explain:   |  |   |  |
| 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)  |  |   |  |
| 1 <input type="checkbox"/> Caucasian  | 5a <input type="checkbox"/> Native American Indian | A <input type="checkbox"/> Amerasian  | N <input type="checkbox"/> Asian Indian        |
| 2 <input type="checkbox"/> Hispanic   | 5b <input type="checkbox"/> Alaskan Native         | C <input type="checkbox"/> Chinese  | P <input type="checkbox"/> Hawaiian            |
| 3 <input type="checkbox"/> Black/African American   | 7 <input type="checkbox"/> Filipino                | H <input type="checkbox"/> Cambodian  | R <input type="checkbox"/> Guamanian           |
| 4 <input type="checkbox"/> Asian  |  | J <input type="checkbox"/> Japanese   | T <input type="checkbox"/> Laotian             |
|   |  | K <input type="checkbox"/> Korean   | V <input type="checkbox"/> Vietnamese          |
|   |  | M <input type="checkbox"/> Samoan   | Z <input type="checkbox"/> Other               |

### FOR UNICARE USE ONLY – DO NOT WRITE BELOW

|           |                 |                |                |                  |  |
|-----------|-----------------|----------------|----------------|------------------|--|
| Group No. | Certificate No. | Agent I.D. No. | Effective Date | X Ref. Cert. No. | <input type="checkbox"/> AA<br><input type="checkbox"/> AR |
| By        | Date            |                |                |                  |  |

**2. Choice of UniCare Individual Coverage**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> FIT 500 (DS53)<br>(Not available eff. 7/1/08)           | <input type="checkbox"/> UniCare Solaura <sup>SM</sup> HSA Plan 1a*<br>(BK55) (Z177 eff. 7/1/08) | <input type="checkbox"/> Consumer Choice<br>\$5000 (DV92)<br>(Z187 eff. 7/1/08) | <input type="checkbox"/> HSA-Compatible Variable-Deductible<br>Plan* (DV97) (Z188 eff. 7/1/08)   |
| <input type="checkbox"/> FIT 1000 (DS54)<br>(Enhanced Z118 eff. 7/1/08)          | <input type="checkbox"/> UniCare Solaura <sup>SM</sup> HSA Plan 2a*<br>(BK56) (Z178 eff. 7/1/08) |   | <input type="checkbox"/> HSA-Compatible (\$2,600/\$5,200)<br>Plan 2* (DV95) (Z189 eff. 7/1/08)   |
| <input type="checkbox"/> FIT 1500 (DS55)<br>(Enhanced Z119 eff. 7/1/08)          | <input type="checkbox"/> UniCare Solaura <sup>SM</sup> HIA Plus 1<br>(BK64) (Z181 eff. 7/1/08)   | <input type="checkbox"/> Consumer Choice<br>\$2000 (DV91)<br>(Z186 eff. 7/1/08) | <input type="checkbox"/> HSA-Compatible Variable Contribution<br>Plan* (DV98) (Z191 eff. 7/1/08) |
| <input type="checkbox"/> FIT 2000 (DS56)<br>(Not available eff. 7/1/08)          | <input type="checkbox"/> UniCare Solaura <sup>SM</sup> HIA Plus 2<br>(BK65) (Z182 eff. 7/1/08)   |   | <input type="checkbox"/> HSA-Compatible (\$5,000/\$10,000)<br>Plan 3* (DV96) (Z190 eff. 7/1/08)  |
| <input type="checkbox"/> Enhanced FIT 2500<br>(Z120 eff. 7/1/08)                 | <input type="checkbox"/> UniCare Solaura <sup>SM</sup> HIA Plus 3<br>(CU59) (Z183 eff. 7/1/08)   | <input type="checkbox"/> Consumer Choice<br>\$1000 (DV90)<br>(Z185 eff. 7/1/08) | <input type="checkbox"/> Life  |
| <input type="checkbox"/> FIT 3000 (DV80) (Enhanced<br>Not available eff. 7/1/08) | <input type="checkbox"/> UniCare Solaura <sup>SM</sup> HIA 1 (CU60)<br>(Z179 eff. 7/1/08)        |   | <input type="checkbox"/> Dental  |
| <input type="checkbox"/> Enhanced FIT 3500<br>(Z121 eff. 7/1/08)                 | <input type="checkbox"/> UniCare Solaura <sup>SM</sup> HIA 2 (CU61)<br>(Z180 eff. 7/1/08)        |   | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> FIT 5000 (DV81)<br>(Enhanced Z122 eff. 7/1/08)          |  |   |  |
| <input type="checkbox"/> Saver 2000 (DV82)<br>(Z169 eff. 7/1/08)                 |  |   |  |

\* For UniCare HSA Plans, please complete the following:

- Yes, I do want to establish a Health Savings Account with UniCare's banking partner. Please forward my information to UniCare's banking partner. I understand that this includes my name, address, and social security number. (SSN required)
- No, I do not want to establish a Health Savings Account with UniCare's banking partner. Please do not forward my information to UniCare's banking partner.

**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 |        | Date of Birth | Social Security No. | FamilyFlex*<br>List Medical Plan code number(s) from Section 2 | Dental | UNICARE USE ONLY |     |
|---|-----------|------------|------|------------------|--------|---------------|---------------------|--|--------|------------------|-----|
|   |           |            |      | Height           | Weight |               |                     |  |        | WVR              | WVR |
| <input type="checkbox"/> Male<br><input type="checkbox"/> Female  | Yourself  |            |      |                  |        |               |                     |  |        |                  |     |
| <input type="checkbox"/> Husband<br><input type="checkbox"/> Wife | Spouse    |            |      |                  |        |               |                     |  |        |                  |     |
| <input type="checkbox"/> Son<br><input type="checkbox"/> Daughter |           |            |      |                  |        |               |                     |  |        |                  |     |
| <input type="checkbox"/> Son<br><input type="checkbox"/> Daughter |           |            |      |                  |        |               |                     |  |        |                  |     |
| <input type="checkbox"/> Son<br><input type="checkbox"/> Daughter |           |            |      |                  |        |               |                     |  |        |                  |     |
| <input type="checkbox"/> Son<br><input type="checkbox"/> Daughter |           |            |      |                  |        |               |                     |  |        |                  |     |

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

**4. 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 and attach the Certificate of Creditable Coverage from your prior health insurance carrier.  
 List all carriers and use additional sheets if necessary.

|                    |                      |                |          |
|--------------------|----------------------|----------------|----------|
| 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:

Has any applicant had coverage in the last 63 days? .....  Yes  No

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

**C.** 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.

**D.** 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 |
| 3. Name of applicant | Name of Insurance Company | Explain |

**E.** Are any persons applying for coverage on this application eligible for Medicare 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)

**F.** 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<br>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.

**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 or consultation recommended, received treatment, or been hospitalized for or diagnosed with any of the following conditions listed in questions 1 through 24 **within the last 10 years**:

|  |   |
|--|---|
| <p>1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis or any other neurological or central nervous system disorder(s) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>18. Male applicant(s)<br/>a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction or implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <p>2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy or any similar symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  | <p>19. Female applicant(s)<br/>a) Breast disorder/cyst, lump, fibroid tumors, silicone injections or implants <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever or any other circulatory condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>b) Pelvic pain, menstruation disorders, including but not limited to irregular periods or menstrual cycles, abnormal pelvic exam/Pap smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <p>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), chronic obstructed pulmonary disease (COPD), tuberculosis, emphysema, or any other respiratory disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>c) Date and result of last pelvic exam/Pap smear for each female over 16:<br/>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal<br/>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal<br/>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> |
| <p>6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring or use of a sleep monitoring device <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  | <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <p>8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids or any other digestive disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  | <p>21. Diseases or problems of the ears or hearing, implant or hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <p>9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain or hepatitis (indicate type: _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  | <p>22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>23. Mental or physical impairment or deformity, congenital abnormalities or birth defects<br/>Specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>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 <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>12. Physical handicap, joint replacement, (pins, plates, screws, etc.), amputation or prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>Has any person listed on this application <b>ever</b>:<br/>25. Had cancer, tumor/growth, leukemia or cyst? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>13. Diabetes, thyroid, pituitary, adrenal, elevated cholesterol or any other metabolic endocrine disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing, surgery, treatment or further evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |
| <p>14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  | <p>27. Seen, been a patient in a hospital, clinic, or other medical facility, including wellness visits and routine exams, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>       |
| <p>15. Is any applicant a candidate for or a recipient of an organ or bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   | <p>28. Been diagnosed as having 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <p>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 <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |   |
| <p>17. Sexually transmitted disease, such as herpes, genital warts, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>  |   |

**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.)

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| <b>Applicant's Social Security No.</b> |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

|                   |   |  |   |                 |                   |               |
|-------------------|---|--|---|-----------------|-------------------|---------------|
| <b>Question #</b> | 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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | <input type="checkbox"/> Still under treatment | Medications                               |                 |                   | Frequency     |
|                   | If abnormal, please explain:  |  | Dosage                                    | Date Prescribed | Date Discontinued |               |

|                   |   |  |   |                 |                   |               |
|-------------------|---|--|---|-----------------|-------------------|---------------|
| <b>Question #</b> | 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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | <input type="checkbox"/> Still under treatment | Medications                               |                 |                   | Frequency     |
|                   | If abnormal, please explain:  |  | Dosage                                    | Date Prescribed | Date Discontinued |               |

|                   |   |  |   |                 |                   |               |
|-------------------|---|--|---|-----------------|-------------------|---------------|
| <b>Question #</b> | 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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | <input type="checkbox"/> Still under treatment | Medications                               |                 |                   | Frequency     |
|                   | If abnormal, please explain:  |  | Dosage                                    | Date Prescribed | Date Discontinued |               |

**6C. Prescription Medications - List all medications not noted above taken or prescribed 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 six months? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.                                    | 1. Family member   |                   | 2. Family member   |                   |
|  | Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month |                   | Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month |                   |
|  | Type of Product  |                   | Type of Product  |                   |
| 5. Has any applicant been advised to reduce alcohol intake within the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

|  |                               |
|--|-------------------------------|
|  | <b>No. of sheets attached</b> |
|--|-------------------------------|

## 7. Conditions of Application

Applicant's Social Security No.

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

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 nonparticipating 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. Please note that surrendering your other coverage prior to approval of a UniCare policy could result in no coverage if the UniCare application is denied. NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.

- If UniCare approves my application, please assign an effective date of the first day after UniCare's approval.
- If UniCare approves my application, please assign an effective date of the
  - 1st of the month following approval.
  - \_\_\_\_\_ (mm/dd/yy).

The effective 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, ONLY UNICARE CAN CHANGE THIS DATE. ONCE THIS POLICY IS ISSUED, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES.

Initial X \_\_\_\_\_

### Billing Date

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

### Family Split Application Option

UniCare offers different levels of premiums. Applicants with certain medical conditions may be offered coverage at a higher rate or tier.

The rating tier offered is determined during the underwriting process. Although each family member on the application is underwritten individually, the rating tier is applied to the entire family policy.

However, if you choose, you have the option to "split" the application. If you choose this option, once it has been determined that one or more applicants will be placed into a higher rating tier, the application will be split with the rated person(s) on one application and any remaining applicants processed separately.

This split may result in separate effective dates, separate billing and in the case of family applications, premium differences. In addition, if more than one policy is issued, separate annual family deductible and out-of-pocket maximums must be satisfied.

For purposes of the HSA-compatible plans, multiple policies may result in a lower contribution maximum into a Health Savings Account. Please contact your tax advisor if you plan on opening a Health Savings Account to use in conjunction with the HSA-compatible plan that you are applying for under the Family Split Application Option.

If, after due consideration and discussing these options with your agent, you would like to take advantage of this offer, please initial below.

I have read the above and understand that in initialing this I accept that in the event that one or more persons on my application is placed into a higher rating tier that my application will be split and, if approved, more than one policy will be issued. I have discussed this option with my agent and understand that my monthly premium, annual deductible, and annual out-of-pocket maximum may be affected. In addition, I understand that my family and I may receive separate bills and different policy effective dates.

\_\_\_\_\_  
Initials of Applicant

\_\_\_\_\_  
Date

### Agreement (All applicants)

I, the undersigned, agree to the following:

1. I understand and agree to pay a separate non-refundable application fee of \$25 and the premium amount required with this application. Payment for the premium 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 requested, 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 payment will not be processed.
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) agree that 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, and/or 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. I certify that my employer will not, directly or indirectly, contribute to any premium payments for this policy, including through a health reimbursement arrangement (HRA) or Internal Revenue Code 125 Plan (cafeteria plan).

9. UniCare may need to request additional medical information from my provider, and this may delay processing of this application. If the health care provider charges a fee for providing this information, UniCare will determine payment, and I will be responsible for any difference.
10. I understand that in considering my application, UniCare may use any information prior to the effective date of coverage, including medical conditions which occur after the signature date and before the original effective date.
11. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.
12. 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 for all persons listed on the application from the original effective date of the agreement for such material intentional misstatements or

omissions. Any fraud or misstatements on the application may lead to rescission of the policy and, if applicable, possible disqualification of the HSA and adverse tax implications.

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.

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

### Authorization/Disclosure Statement

Some of the plans offered do not include all of the state-mandated health benefits. The Consumer Choice PPO Plans do not provide some of the state-mandated health benefits. State-mandated benefits not included are: 1) mental or nervous disorder including those with organic disease; 2) off-label drugs; 3) prescription contraceptive drugs and devices and related services; 4) telemedicine/telehealth; 5) acquired brain injury. In addition, coinsurance differentials between participating and nonparticipating providers may be greater than 30%. Purchase of this plan may limit your future coverage options in the event your health changes and needed benefits are not available under this plan. Coverage for pregnancy is not available under any UniCare Life & Health Insurance Company (UniCare) Individual and Family PPO Plan.

**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 diagnostic or other healthcare 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 and/or its affiliates 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 a period not longer than 2 years 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 the above disclosure statement. I have read and understand this Application in its entirety. I have received a written plan description.

### 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 |

**8. Premium payment and nonrefundable \$25 application fee required with application. Please choose payment method from 8A.** The application fee is waived for applications submitted online, through a UniCare-supported online process. Only one application fee is required for families submitting more than one application at the same time.

**Note:** The premium amount may change during the Underwriting process as a result of being placed into a higher rating tier.

**For Summary Bill, attach Summary Bill Forms.**

**8A. Please choose from the following options for initial and future payments.**

If you choose ongoing Quarterly Paper Billing, a \$5 administrative fee applies to each paper bill.

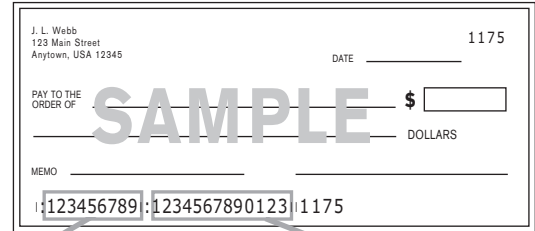
- Initial and ongoing Monthly Checking Account Deduction (complete section 8B)
- Initial Credit Card payment (complete section 8C) and ongoing Monthly Checking Account Deduction (complete section 8B)
- Initial Credit Card payment (complete section 8C) and ongoing Quarterly Paper Bill
- Initial Electronic Check (complete section 8D) and ongoing Quarterly Paper Bill
- Initial Paper Check\* and ongoing Monthly Checking Account Deduction (complete section 8B) **(This option is not available when applying via the Internet)**
- Initial Paper Check\* and ongoing Quarterly Paper Bill **(This option is not available when applying via the Internet)**

**8B. Monthly Checking Account Deduction**

By providing your check information, you authorize us to electronically debit your bank account. If you have not sent in an initial payment, your bank account will be debited one month's premium the day after approval. This will include all products selected, including dental and/or life and the non-refundable \$25 application fee. Subsequent premium amounts will be debited from your checking account on the day you request below.

**Requested Debit Day:**

1st  8th  15th  22nd of each month  
 If no date is requested, your premiums will be debited on the first of each month. If you select a draft date other than the first, premiums will be debited a month in advance (prior to the due date).



Provide your Routing and Account numbers here.



|                  |                  |
|------------------|------------------|
| Bank Routing No. | Bank Account No. |
|------------------|------------------|

**Authorization:**

As a convenience to me, I request and authorize UniCare Life & Health Insurance Company and/or its affiliates (UniCare) 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 understand that the initial payment amount may vary as a result of changes during underwriting and/or subsequent payment amounts may vary as a result of changes I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. I agree that UniCare's rights in respect to each such debit shall be the same as if it were a check 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 by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit was 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 Checking Account Deduction and billed quarterly.

|  |                                       |      |
|--|---------------------------------------|------|
| Applicant Name   | Name of Bank or Financial Institution |      |
| Authorized Signature<br>(as it appears in the financial institution's records) | Name on Checking Account (PRINT)      | Date |

\* By sending your paper check, you authorize UniCare to convert your check into a one-time electronic funds transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. 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. Not available for applications submitted online. Business checks are not acceptable.

**8C. One-Time Credit Card Payments**

|   |  |      |
|---|--|------|
| <b>Credit Card:</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <b>Select One:</b> <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months |  |      |
| Card No.: _____ Exp. : ____/____ Cardholder ZIP Code: _____<br>(16 digits only)   |  |      |
| Authorized Signature (As it appears on the credit card)<br><b>X</b>   | Cardholder Name (As it appears on the credit card) | Date |

**8D. Electronic Check**

|  |                  |                      |                          |           |
|--|------------------|----------------------|--------------------------|-----------|
| In lieu of sending a Paper Check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use. Business checks are not acceptable. |                  |                      |                          |           |
| <b>Select One:</b> <input type="checkbox"/> 1 month and \$25 Application Fee <input type="checkbox"/> 3 months and \$25 Application Fee  |                  |                      |                          |           |
| Name on Checking Account (PRINT)   | Bank Routing No. | Checking Account No. | Total Amount<br>\$ _____ | Check No. |

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| <b>Applicant's Social Security No.</b> |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

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

**10. To be completed by your UniCare-Appointed Agent**

|  |   |
|--|---|
| <p>■ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>■ Did you see the applicant (and spouse, if applying) at the time this application was executed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If no, please explain:<br/><br/>_____</p> <p>■ I verify that this application was completed by the applicant unless the Statement of Accountability (Section 11) was completed. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>■ Breakdown of funds collected:</p> <p>Total Medical premium . . . . . \$ .....</p> <p>Total Dental premium . . . . . \$ .....</p> <p>Total Life premium. . . . . \$ .....</p> <p>Nonrefundable application fee. . . . . \$ \$25 .....</p> <p><b>Total funds collected</b> . . . . . \$ .....</p> <p>■ Was the Monthly Checking Account Deduction Authorization (Section 8B) completed? (only if applicable).. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>■ Was a Conditional Receipt given? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

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

**For overnight delivery: UniCare, Attn – Individual Medical Underwriting Department, 233 S. Wacker Drive, Suite 3900, Chicago, IL 60606-6309**

**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 **X** \_\_\_\_\_  
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 nonrefundable application fee payable to UniCare;  
\$ \_\_\_\_\_ as a premium, payable to UniCare.

Subject to the following:

**IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE 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. IF YOU DO NOT QUALIFY FOR COVERAGE YOUR INITIAL PREMIUM PAYMENT WILL NOT BE PROCESSED.**

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By **X** \_\_\_\_\_  
Signature of Agent Agent I.D. Number

TXIAPLCR0305

**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. UniCare may also provide information to a health care provider 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 correct that information 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.



## Notes