

4. COVERAGE DECLINATION – To be completed if any coverage is declined or refused by an eligible employee and/or their eligible family members.

A. Medical Coverage declined: Myself Spouse Dependent(s) Spouse and Dependent(s)

B. Dental Coverage declined for:

Reason for declining coverage: (Check one)

- Myself
 Spouse
 Dependent(s)
 Spouse and Dependent(s)

C. Life Insurance declined for:

- Myself
 Dependent(s)

- Covered by spouse's group coverage – Carrier name and I.D. Number: _____
 Covered by UNICARE Individual Policy
 Enrolled in any other Insurance Carrier Plans – Carrier name: _____
 Spouse covered by employer's group medical coverage
 Medicare
 Covered by TRICARE
 Other (Explain): _____

I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily and no one has tried to influence me or put any pressure on me to decline coverage. By declining this group medical coverage (unless employee and/or dependent(s) have group medical coverage elsewhere*), I acknowledge that if I wish to enroll at a later date, my dependent(s) and I will have to wait until the next open enrollment period in this group medical and/or group life insurance plan. Pre-existing conditions may not be covered for twelve (12) months.

X

Signature if declining coverage for employee/dependent(s)

Date (Month / Day / Year)

* If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or being party in a suit for adoption or placement for adoption, coverage is available to you and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or becoming a party in a suit for adoption or placement for adoption. If a court has ordered you to provide coverage for a child, coverage is available for yourself and the child. Coverage for the child will be automatic for the first 31 days from the date the employer receives notification of the court order. To continue coverage beyond 31 days, we must be notified, the employee must enroll and the required premium must be paid within the 31 day period. If you notify us after that 31 day period, your child's coverage will become effective in accordance with the provisions for late enrollment.

5. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 2-50 EMPLOYEES AND LATE ENROLLEES

(Include information on all family members you wish to cover.)

All questions must be answered "yes" or "no." INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Within the last 10 years, has any person listed on this application, had any signs or symptoms, had a consultation for, received advice for, sought diagnosis or treatment for, had treatment recommended for, received treatment (including medication) for, or been hospitalized for any of the following conditions? | | |
| a. Heart attack, heart murmur, disorder of the heart, stroke, chest pain, high blood pressure, anemia, varicose veins, or any disorder of the blood, blood vessels, hyperlipemia or arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ulcer, colitis, gallstone, hernia, or any other disorder of the stomach, intestines, rectum, gall bladder, or liver | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cancer, cyst, tumor, or growth | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, urinary system, or male or female organs | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Tuberculosis, asthma, hay fever, adenoids, pleurisy, or any other disorder of the lungs or respiratory system | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Epilepsy, fainting spells, mental or nervous condition, paralysis, or any disorder of the brain or nervous system | <input type="checkbox"/> | <input type="checkbox"/> |
| If epileptic, date of last seizure: _____ | | |
| g. Arthritis, rheumatic fever, back trouble, TMJ, or any other disorder of the joints, muscles, or bones | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any physical deformity or defect, serious bodily injury, fracture, concussion, burn and/or congenital problems, or any cosmetic surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the last 10 years, has any person listed on this application: | | |
| a. Had any surgery, been advised to have surgery, or been confined to a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been medically diagnosed with an immune deficiency disorder, AIDS, or AIDS related complex, or been diagnosed as HIV positive? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is any person listed on this application: | | |
| a. Currently under treatment, receiving counseling or taking medicine for any condition or disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Currently pregnant or is any male expecting a child with anyone, whether listed on this application or not? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, due date (Month, Day, Year) _____ Any history of complication of pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A user of tobacco products within the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |

5A. IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ON THE PREVIOUS PAGE, YOU MUST COMPLETE THE FOLLOWING:

Please explain and provide us with **FULL DETAILS** for each "Yes" answer to any condition(s) checked in all the preceding boxes.
(Attach additional sheets, if necessary.)

QUESTION #	NAME OF FAMILY MEMBER (As identified on Physician's Record)	NAME OF HOSPITAL, CLINIC, AND/OR PERSON PROVIDING CARE	PHONE NO. ()
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED <input type="checkbox"/> Still under treatment	ADDRESS	SUITE NO.
NAME OF CONDITION/ILLNESS		CITY / STATE / ZIP CODE	FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS		MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE	
QUESTION #	NAME OF FAMILY MEMBER (As identified on Physician's Record)	NAME OF HOSPITAL, CLINIC, AND/OR PERSON PROVIDING CARE	PHONE NO. ()
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED <input type="checkbox"/> Still under treatment	ADDRESS	SUITE NO.
NAME OF CONDITION/ILLNESS		CITY / STATE / ZIP CODE	FAX NO. ()
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DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED <input type="checkbox"/> Still under treatment	ADDRESS	SUITE NO.
NAME OF CONDITION/ILLNESS		CITY / STATE / ZIP CODE	FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS		MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE	

6. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 51-99 EMPLOYEES

- Within the last 10 years, has any person on this application had any signs or symptoms, had a consultation for, received advice for, sought diagnosis or treatment for, had treatment recommended for, received treatment (including medication) for, or been hospitalized for any of the following conditions?

a. Cardiovascular disease or heart disorders, strokes, disorders of the kidney, stomach, intestines or liver; mental or nervous conditions; central nervous system disorders, diabetes; any disorders of the lungs or respiratory system or cancer?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
b. Immune deficiency disorder, AIDS, AIDS related complex, or been diagnosed as HIV positive?	<input type="checkbox"/>		<input type="checkbox"/>	
- During the last 24 months, has any person listed on this application had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than \$5,000?
- Is any person listed on this application:

a. Currently under treatment, receiving counseling or taking medicine for any condition or disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Currently pregnant or is any male expecting a child with anyone, whether listed on this application or not?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, due date (Month, Day, Year) _____		
c. A user of tobacco products within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>

If you answer "YES" to any of the above questions, complete the following: (Attach additional sheets if necessary).

Name of patient: _____	Name of patient: _____
Condition/Illness: _____	Condition/Illness: _____
Dates of treatment: From _____ Through _____	Dates of treatment: From _____ Through _____
Treatment rendered: _____	Treatment rendered: _____
Still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication and dosage taken: _____	Medication and dosage taken: _____
Date: From _____ Through _____	Date: From _____ Through _____
Treating providers, name/address: _____	Treating providers, name/address: _____
_____	_____

7. OTHER MEDICAL COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS (All questions must be answered.)

	Yes	No
1. Do any persons on this application intend to continue other Group coverage if this application is accepted?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, name of person: _____		
Insurance Co. _____ Policy No. _____		
2. Does any person applying for coverage currently have health insurance coverage?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Proof of Coverage must be submitted. (See below.)		
Has any person applying for coverage had health insurance coverage at any time in the past twelve (12) months?	<input type="checkbox"/>	<input type="checkbox"/>
(Any Individual UNICARE coverage must be terminated if and when issued by this Group Medical Plan.)		
If yes, Name: _____		
Type of coverage: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other (specify): _____		
Insurance Co: _____		
Date coverage began: _____ Date ended: _____		
3. Does any person applying for coverage currently have Dental Insurance Coverage?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Type: _____ Insurance Co: _____		
Date coverage began: _____ Date ended: _____		
4. Is any person applying for coverage eligible for Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Name: _____		

PROOF OF PRIOR COVERAGE (Required)
IMPORTANT – Proof of coverage must accompany this application for pre-existing condition credit.
 Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of medical premium bill from prior carrier showing first month's premium and last month's premium.
3. Copy of front and back of insurance card; phone number of prior carrier and completed HIPAA authorization form (available upon request) giving us permission to obtain prior coverage information from previous carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member to the full pre-existing conditions limitation with no credit for prior coverage. You are entitled to a Certificate of Creditable Coverage from your prior carrier. UNICARE will assist in obtaining this information on your behalf should the need arise. Pre-existing conditions are signs, symptoms, or conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the eligibility date; the exclusion extends for not more than 12 months and the exclusion is reduced by the aggregate of the periods of prior creditable coverage.

8. AUTHORIZATION/DISCLOSURE STATEMENT (The following Authorization is to be signed by all employees applying for coverage.)

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage is issued under the plan. I further authorize my employer to deduct my contribution, if any, from my earnings towards the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours per week.

I understand that my eligible employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been accepted and approved by UNICARE.

Even if this application is approved, any material or intentional misstatements or omissions may result in future claims being denied and the policy, or your coverage under the policy, being rescinded or re-evaluated, as of the effective date, for eligibility and rating purposes. For purposes of non-renewal or cancellation of coverage, with respect to Groups with no more than 50 eligible employees, an intentional misstatement of a material fact does not include any misrepresentation regarding health status. However, coverage may be non-renewed or cancelled in the event of fraud.

I am applying for Participating Provider Plan coverage: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

The Consumer Choice Plan(s) do not provide some state-mandated health benefits. For Groups with no more than 50 eligible employees, state-mandated benefits not included are: 1) Serious Mental Illness; 2) Oral contraceptives, prescription contraceptive drugs and devices and related services (unless the plan includes maternity benefits); 3) Chemical Dependency; 4) In-Vitro fertilization, and 5) Speech and Hearing. In addition, coinsurance differentials are 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.

The Consumer Choice Plan(s) do not provide some state-mandated health benefits. For Groups with more than 50 eligible employees, state-mandated benefits not included are: 1) Telemedicine/Telehealth; 2) Chemical Dependency; 3) In-Vitro fertilization, and 4) Speech and Hearing. In addition, coinsurance differentials are 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.

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 Life & Health Insurance Company (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.

8. AUTHORIZATION/DISCLOSURE STATEMENT CONTINUED *(The following Authorization is to be signed by all employees applying for coverage.)*

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 that my employer's application will determine the coverages in force and that coverage is not in force if an application for that coverage has not been made by my employer.

I understand that I am entitled to a copy of this signed authorization if I request it.

Arbitration Agreement: I understand that any dispute between me and UNICARE may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing such arbitration. The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the policyholder or, if applicable, beneficiary resides. By signing this application, I am not agreeing to binding arbitration.

If I am enrolling in an Employer-sponsored plan that is subject to ERISA, I understand that any dispute involving an adverse benefit decision may be submitted to voluntary binding arbitration only after the ERISA appeal process is completed.

I, the applicant, acknowledge that I have read and understand this Application in its entirety.

SIGNATURE OF EMPLOYEE <i>(Required)</i>	TODAY'S DATE <i>(Required)</i>	SIGNATURE OF EMPLOYEE'S SPOUSE <i>(If applying for coverage)</i>	TODAY'S DATE <i>(Required)</i>
X		X	

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.



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