



UNICARE Life & Health Insurance Company

Individual Change of Coverage Application

(FOR EXISTING INSUREDS ONLY)

INSTRUCTIONS: Thank you for applying with UNICARE. Please follow the instructions to allow us to better process your application.

1. Choice of UNICARE Coverage – Choose the Plan in which you wish to enroll.

Please note, some Plans may not be available in your area. Check with UNICARE or your agent for Plan availability. Please print in black ink.

Performance Plans: \$500 Deductible \$1,000 Deductible \$2,000 Deductible \$5,000 Deductible
 \$600 Deductible \$1,500 Deductible \$3,000 Deductible

UNICARE Performance Plus No Deductible: \$30 Co-Pay

UNICARE Saver 2000: \$2,000 Deductible

Additional Coverage: Term Life Insurance – (Please include a separate Life application addendum.)
 UNICARE Individual Dental Fee for Service Plan

2. Insured Information – Currently insured must complete this application.

Height and weight must be stated accurately.

SEX	NAME: Last	First	M.I.	HEIGHT	WEIGHT	AGE	BIRTHDATE Month / Day / Year	SOCIAL SECURITY NO.	MARITAL STATUS	UNICARE USE ONLY			
										WVR	DUR	WVR	DUR
<input type="checkbox"/> Male <input type="checkbox"/> Female									<input type="checkbox"/> Married <input type="checkbox"/> Single				
RESIDENCE ADDRESS						BILLING ADDRESS							
Street Address						Street Address							
City / State / ZIP						City / State / ZIP							
Home Phone No.			Business Phone No.			In Care Of:							
Occupation			Name of Employer			Spouse's Social Security No. (If not applying)			Applicant/Spouse Maiden Name (If applicable)				

3. Insured Family Information –

Please list yourself and all eligible family members requesting a change in coverage.

Height and weight must be stated accurately.

Check one: Insure all eligible applicants Insure no one unless all are accepted for coverage.

RELATION	SEX	NAME: Last	First	M.I.	HEIGHT	WEIGHT	AGE	BIRTHDATE Month / Day / Year	SOCIAL SECURITY NO.	FULL-TIME STUDENT	UNICARE USE ONLY			
											WVR	DUR	WVR	DUR
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F													
	<input type="checkbox"/> Yes <input type="checkbox"/> No													
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> Yes <input type="checkbox"/> No				

4. Health History of Insureds Currently Listed on This Application –

Your claims history with UNICARE will also be used in addition to history listed on this application.

- A. Is either the applicant, spouse, or any female dependent, whether or not listed on the application, currently pregnant or in the process of adoption? Yes No
- B. Is any male listed on this application expecting a child with anyone, whether or not the mother is listed on the application? Yes No
- C. Has any insured family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 12 months whether or not claims have been submitted? Yes No
- If yes, please provide the required information below.

INSURED NAME	PHYSICIAN / HOSPITAL / PROVIDER AND ADDRESS	MEDICATION NAME	CONDITION / ILLNESS TREATED

For UNICARE Use Only

GROUP NO.	CERTIFICATE NO.	AGENT TAX I.D. NO.	EFFECTIVE DATE	X REF. CERT. NO.	<input type="checkbox"/> AA <input type="checkbox"/> AR	BY	DATE
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5. Conditions of Application – It is important that you carefully read and understand the following:

All applicants age 18 and over must personally read, agree to and sign the following:

Applicant does does not read English.

If an applicant does not read English, the translator must sign and submit a statement of accountability for translating this entire application. UNICARE will enroll all eligible applicants unless otherwise instructed.

I, the applicant, request that UNICARE not enroll eligible applicants unless **all** family members qualify.

I, the undersigned, understand that:

1. If my application for UNICARE coverage is accepted as applied for, UNICARE will assign the effective date, but I agree I have no coverage under this application until notified in writing by UNICARE that I am accepted.

2. I understand that UNICARE has the right to deny my application and if so, I will be notified in writing.

3. **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.

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

If the responsible adult is not the natural parent, please submit court papers authorizing guardianship.

PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing the 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.

4. **DEPENDENTS AGE 18 AND OVER:** I represent that 1) my dependents age 18 and over 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 with dependents age 18 and over, and 3) all information contained in this application regarding dependents age 18 and over is complete and accurate.

5. UNICARE may request additional information and this may delay processing of this application. If the health care provider bills for these services, UNICARE will determine payment, and I will be responsible for any difference.

6. **The selling agent has no authority to promise me coverage or to modify UNICARE underwriting policy or terms of any UNICARE coverage.**

7. **I, alone, am responsible for reading and accurately completing 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 on this application 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 an act or practice that constitutes fraud, or for any intentional misrepresentation of material fact, relating in any way to the plan, including claims for benefits under the plan.**

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

9. **MATERNITY BENEFITS:** I understand that not all UNICARE Plans include maternity benefits. I am also aware that, if I change coverage, my new Plan my not include maternity benefits.

AUTHORIZATION – Signature and date required.

I hereby authorize any health care facility, physician, surgeon, counselor or therapist to provide UNICARE or employees, including my UNICARE agent or broker, all information pertaining to any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), furnished to me or my dependent who are also applying for coverage, and any illness, injury, or condition that I or these dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below for as long as I am validly covered under a UNICARE Plan or as allowed by the state law. A photocopy of this Authorization is as valid as the original. My authorized representative, UNICARE agent, or I am entitled to receive a copy of this form. I have personally read and completed this application. I understand and agree to all the Conditions of Application and the Authorization. I understand that coverage will come into effect only if this application is approved by UNICARE.

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

Signature of Applicant / Parent or Legal Guardian X	Date (Required)	Signature of Applicant's Spouse X	Date (Required)
Signature of Applicant's Dependent age 18 or over X	Date (Required)	Signature of Applicant's Dependent age 18 or over X	Date (Required)

Agent Instructions

Your client must personally read and complete this application. If your client does not read and write English, a statement of translation accountability must accompany this application.

If the legal guardian is other than the natural parent, court appointed guardianship papers must accompany this application.

If the underage applicant does not reside with the insured, the custodial parent must complete the minor's health questionnaire. The insured may sign for financial accountability.

Please answer all questions below after the applicant(s) has (have) completed the application.

1. Are you aware of any information not disclosed on this application relating to health, habits or reputation of any person listed on this application which might have a bearing on risk? Yes No

Please explain a "Yes" answer on a separate sheet of paper and submit with application.

2. Did you personally see the applicants at the time this application was completed? Yes No

Agent's Signature	Agent's Tax I.D. No.	Agent's Street Address		
Agent's Name (Please Print)	Phone No. ()	City	State	ZIP Code