UNICARE®

ILLINOIS
INDIVIDUAL CHANGE OF COVERAGE APPLICATION

(For Existing Insureds Only)

UniCare Health Insurance Company of the Midwest

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

Primary Insured's Social Security No.

1. Insured Information *(Please Print)*

Primary Insured's Last Name	First Name M.I.		Home Phone No. ( )	E-mail Address *(Optional)*
Home Address *(Residence address required; P.O. Box not acceptable)*			Daytime Phone No. ( )	Fax. No. ( )
City	State	ZIP Code	Marital Status ☐ Single ☐ Married	Spouse's Social Security No. *(Required)*
Mailing Address *(If different from above)*	(P.O. Box or Personal Mail Box No.)		Maiden Name of Insured/Spouse *(If applicable)*	
City	State	ZIP Code	In care of: *(If applicable)*	

2. Choice of UniCare Individual Coverage

☐ FIT 500 (BK77)
☐ FIT 1000 (BK78)
☐ FIT 1500 (BK79)
☐ FIT 2000 (BK80)
☐ FIT 3000 (BK81)
☐ FIT 5000 (BK82)
☐ Saver 2000 (G846)

☐ HSA-Compatible Variable-Deductible Plan (T779)
☐ HSA-Compatible ($2,600/$5,200) Plan 2 (T083)
☐ HSA-Compatible Variable-Contribution Plan (X442)
☐ HSA-Compatible ($5,000/$10,000) Plan 3 (T084)
☐ Other_____(_____)

☐ Life
☐ Dental

3. Insured Family Information – *Height and weight must be stated correctly*

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	List Medical Plan code number(s) from Section 2 FamilyFlex®	✓ Dental	UNICARE USE ONLY WVR	UNICARE USE ONLY WVR
☐ Male ☐ Female	Yourself									
☐ Husband ☐ Wife	Spouse									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

For UniCare Use Only

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

4. 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: _____

5. 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 the applicant, spouse, or any female dependent, whether or not listed on this application, currently pregnant or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No

B. Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on the application? ☐ Yes ☐ No

C. Has any insured family member 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, 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.

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

6. Conditions of Application – *It is important that you carefully read and fully understand the following:*

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 7, for translating this entire application. UniCare will enroll all eligible applicants unless otherwise instructed.

I, the undersigned, agree to the following:

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 I am notified in writing by UniCare that my application is approved.
2. If I am accepted, this application will become part of the agreement between UniCare and myself.
3. I understand that UniCare has the right to deny my application and if it does so, I will be notified in writing.
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. **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 with them, and, 3) agree that all information contained in this application regarding them is complete and accurate.
6. 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.
7. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.
8. 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 this 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 recission 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.

   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 Authorization 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.
9. My UniCare agent may receive copies of any correspondence about my medical history when correspondence is required.
10. **MATERNITY BENEFITS:** I understand that not all UniCare plans include maternity benefits. I am also aware that, if I change coverage, my new plan may not include maternity benefits.

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 6). 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

7. Agent Instructions

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 the health, habits or reputation of any person listed on this application which might have a bearing on the risk? ☐ Yes ☐ No
   Please explain a "Yes" answer on a separate sheet of paper and submit with application.
2. Did you see the applicant (and spouse, if applying) at the time this application was executed? ☐ Yes ☐ No
   If no, please explain: _____
3. I verify that this application was completed by the applicant unless the Statement of Accountability (Section 8) was completed. ☐ Yes ☐ No

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

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

I, _____, personally read and completed this Individual Change of Coverage 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 6)."

By X _____ _____

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