



SUPPLEMENT TO INDIVIDUAL ENROLLMENT APPLICATION ILLINOIS

Applicant's Social Security No.										
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UniCare Health Insurance Company of the Midwest

This form provides additional space, if needed, to list applicants and information for medical and/or dental and/or term life insurance coverage, and is a part of your UniCare Individual Enrollment Application.

Primary Applicant's Social Security No.	Primary Applicant's Last Name	First Name	M.I.								
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Applicants 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.	✓ Full Time Student	FamilyFlex® List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY	
				Height	Weight						WVR	WVR
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												

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*			

*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.

Professional Services – Give COMPLETE details of any “Yes” answers to the questions in 6A. (Use additional sheets if necessary.)

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
	Name of Condition/Illness	Date Ended	Address			Phone No.
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
	Results <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	

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	If abnormal, please explain:		Dosage	Date Prescribed	Date Discontinued	

Professional Services (Continued)

Applicant's Social Security									

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

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If abnormal, please explain:			Dosage	Date Prescribed	Date Discontinued	

Prescription Medications -

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

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

Signatures (Required) - Applicants over age 18 must sign and date.

Applicant/parent or legal guardian	Today's date	Applicant's Spouse (required if applying for coverage)	Today's date
Applicant age 18 or over	Today's date	Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date	Applicant age 18 or over	Today's date