

**UNICARE Life & Health Insurance Company**  
**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**

For Seniors with Medicare Parts A and B



**Section 1 – Choice of Coverage**

Please check the box for your choice of Medicare Supplement coverage:

- Standard Plan A       Standard Plan B       Standard Plan C       Standard Plan D  
 Standard Plan F       PrimeChoice<sup>SM</sup> Plan

Check here if you also want to enroll in the **Senior Dental Plan**

**Section 2 – Applicant Information**

This complete original application will be returned to you, for your records, along with your policy when you are enrolled.

**Please copy the information from your Medicare card here** ↓

NAME OF BENEFICIARY (Applicant)	CLAIM NUMBER	SEX
_____	_____	_____
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL INSURANCE _____		
MEDICAL INSURANCE _____		

Requested effective date, or end date of prior Medicare supplement, if replacing: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name (as it appears on your Medicare card): \_\_\_\_\_

Social Security Number: | | | | | | | | | | Date of Birth: \_\_\_\_\_

Home Address, Apt. No., Suite No.: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Billing Address (if different from home address): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Care of/Attention: \_\_\_\_\_

If transferring from another UNICARE Group/Individual or UNICARE out-of-state plan indicate

Group Number: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: | | | | | | | | | |

**Section 3 – Billing Information**

- Annual       Quarterly       Bimonthly       Monthly (Checking Account Deduction Only)

<b>UNICARE Use Only</b>	
Broker Number _____	H/S <input type="checkbox"/> Yes <input type="checkbox"/> No
Amount Received \$ _____	
Group No. _____	Policy No. _____
	Effective Date _____
X Re. Cert. No. _____	

*Insert check face up. Please submit one month's premium for your Medicare supplement plan (and dental plan, if selected), plus an additional one-time non-refundable \$5 processing fee.*

*Please make check or money order for premium payable to UNICARE.*

**Applicant: Please return application to agent or to the mailing address below.**

UNICARE Life & Health Insurance Company,  
Administrative Office, P.O. Box 9063, Oxnard, CA 93031-9063

Section 4 – Health History

THIS SECTION MUST BE COMPLETED BY APPLICANT

Check the box next to any conditions that apply to you.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair for any daily activity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past 2 years, have you been advised to have surgery which has not yet been done?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past 5 years, have you been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions: |                          |                          |
| a. heart conditions including but not limited to heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, stroke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer’s disease, Parkinson’s disease, senile dementia, organic brain disorder, or other senility disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), or emphysema (excluding allergies and asthma)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. internal cancer, leukemia, Hodgkin’s disease, insulin dependent diabetes, chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea), amputation or joint replacement due to disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?   | <input type="checkbox"/> | <input type="checkbox"/> |

List all prescription drugs currently prescribed for your use: (If none, write “none”) \_\_\_\_\_

List name, address and telephone number of prescribing physician if different from below: \_\_\_\_\_

\_\_\_\_\_

**Applicant’s Initials** \_\_\_\_\_

Section 5 – Medical Information

Name of Primary Care Physician: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

## Section 6 – General Information

### ANSWER ALL QUESTIONS IN THIS SECTION

- Do you have another Medicare supplement insurance policy, certificate, or coverage in force?  Yes  No  
 If so, with which company \_\_\_\_\_
- If so, do you intend to replace your current Medicare supplement policy with this policy, certificate or coverage?  Yes  No
- Do you have any other health insurance policies or coverage that provide benefits similar to this Medicare supplement policy?  Yes  No  
 If so, with which company \_\_\_\_\_  
 What kind of policy? \_\_\_\_\_
- Are you covered for medical assistance through the state Medicaid program?  Yes  No  
 If so, as a Specified Low-Income Medicare Beneficiary (SLMB)?  Yes  No  
 If so, as a Qualified Medicare Beneficiary (QMB)?  Yes  No  
 If so, for other Medicaid medical benefits?  Yes  No
- Have you been terminated from previous health coverage or voluntarily disenrolled from a Medicare+Choice plan?  Yes  No

## Section 7 – Conditions of Application

### Please read the following carefully.

- I agree to pay an application fee equal to the premiums required for the plan requested on this application, that this payment will be returned to me if my application is rejected or will be applied to the premiums if my application is accepted.
- UNICARE will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B. If my application is not received during the open enrollment period, UNICARE has the right to reject my application. If UNICARE rejects my application, I will be notified in writing and any application fees submitted with this application will be refunded. I understand and agree that if UNICARE rejects my application, under no circumstances will any UNICARE benefits be payable. ***Cashing of my check by UNICARE does not constitute approval of my application.***

## Optional Monthly Checking Account Deduction Authorization for Seniors

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of UNICARE Life & Health Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and 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 in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be 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.

### Please attach a blank check marked "VOID"

Insured	
<b>x</b>	Date

Social Security Number	
Bank Name	
<b>x</b>	Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

**Section 7 – Conditions of Application (continued)**

3. If my application is accepted, this application will become part of the agreement between UNICARE and myself.
4. The selling agent has no authority to promise me coverage or to modify UNICARE underwriting policy or terms of any UNICARE coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that UNICARE may void all coverage from the original effective date of the policy for material misstatements or omissions.

**Notice to Applicant**

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**Section 8 – Authorization and Agreements**

**CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS**

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**Name**

**ID Number**

**Phone**

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**Address (Street, City, State, Zip)**

**Protected Health Information (PHI) to be Used and/or Disclosed:** Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related complex).

**Entities or Persons Authorized to Use or Disclose:** U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional

**PRIORITY PROCESSING**

**Complete the other side of this form to enroll in the Optional Monthly Checking Account Deduction Authorization for Seniors.**

**Include a blank check marked “VOID”. A deposit slip is not acceptable.**

Section 8 – Authorization and Agreements (continued)

**Entities or Persons Authorized to Receive:** UNICARE Life & Health Insurance Company or affiliate ("UNICARE") its agents, employees, designees, or representatives, including my UNICARE agent or broker.

**Purpose of this Authorization:** By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

**Effect of Declining:** If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you the benefits. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

This authorization is a condition of our paying the claim. If you decide not to sign this authorization we may decline to pay the claim.

**Effect of Granting this Authorization:** The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

**Expiration:** This authorization will expire upon the termination of any UNICARE coverage that may be in effect.

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

UNICARE, PO. Box 9063  
Oxnard, CA 93031-9063

Telephone 800-508-9355, Fax 805-375-0361

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
**Print Name** **Applicant's Signature** **Date**

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

\_\_\_\_\_  
**Personal Representative: Print Name** **Relationship to Individual**

**X** \_\_\_\_\_  
**Applicant's Signature** **Date**

A photocopy of this authorization is as valid as the original, and I and my UNICARE agent or broker are entitled to receive a copy of this form. YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

**Section 8 – Authorization and Agreements (continued)**

■ I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), Conditions of Application and the Authorization. I acknowledge receipt of the “Guide to Health Insurance for People with Medicare,” and “Outline of Medicare Supplement Coverage and Premium Information” as required. I understand that receipt of money with this application does not create UNICARE Life & Health Insurance Company coverage. Coverage will come into effect only if this application is approved by UNICARE Life & Health Insurance Company.

■ The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed Application and that the applicant realizes that any false statement or misrepresentation in the Application may result in the loss of coverage under the policy.

**X** \_\_\_\_\_  
**Applicant’s Signature** **Date of Signature**

**X** \_\_\_\_\_  
**Agent’s Signature** **Date of Signature**

**For Agent Only**

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date	Name of Policy	Name and Address of Insurance Company
From: _____ Mo./Yr.	_____	Name: _____
To: _____ Mo./Yr.		Address: _____
		City/State: _____

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the “Guide to Health Insurance for People with Medicare,” and an outline of coverage and a for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

Agent’s Signature	Date of Signature	(City and State)
Print Agent’s Name		Agent No.
Street Address		Telephone No.
City	State	ZIP
Premium Amount \$ _____		
Send Policy and I.D. Card To:	<input type="checkbox"/> Agent	<input type="checkbox"/> Insured

*The I.D. Card will be sent to the insured in a separate mailing.*

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE**

**This application will be returned to you after processing.**

**WE ADVISE YOU TO SAVE THIS NOTICE AS IT COULD BE VERY IMPORTANT TO YOU IN THE FUTURE.**

According to the information you have furnished, you intend to terminate existing Medicare supplement coverage and replace it with a policy to be issued by UNICARE Life & Health Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY AGENT**

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Other. (Please specify.) \_\_\_\_\_

1. Unless your existing Medicare supplement policy has been in effect for at least six months, health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

\_\_\_\_\_  
Typed Name and Address of Agent

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Receipt for cash received**

Date \_\_\_\_\_ Amount \_\_\_\_\_

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Account \_\_\_\_\_ Check Number \_\_\_\_\_

Policy Description \_\_\_\_\_

Received by \_\_\_\_\_

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.



## Senior Services Toll-Free Number

Monday – Thursday – **8:30 a.m. to 5:30 p.m.**

Friday – **8:30 a.m. to 3:00 p.m.**

**(Eastern Standard Time)**

**(800) 508-WELL**

**(800) 508-9355**

### **Senior Services Toll-Free Number**

Monday – Thursday: 8:30 a.m. to 5:30 p.m. (Eastern Standard Time)

Friday: 8:30 a.m. to 3:00 p.m. (Eastern Standard Time)

(800) 508-WELL–(800) 508-9355

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