



# 2-50 Small Group Employer Application

The various products listed in the application may be offered by any of the following companies: UNICARE Health Insurance Company of the Midwest, UNICARE Health Plans of the Midwest Inc. or UNICARE Life & Health Insurance Company. Please refer to the Employer Policy for the name of the offering company for the products you have selected.

FOR UNICARE USE ONLY											
GROUP NO.				UNDERWRITER NO.				EFFECTIVE DATE			

## 1. EMPLOYER INFORMATION – The employer certifies the following information.

COMPANY NAME				
STREET ADDRESS (P.O. Box not acceptable)		CITY	STATE	ZIP
BILLING ADDRESS		CITY	STATE	ZIP
EMPLOYER IS <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other-Explain: _____				
COMPANY CONTACT PERSON		PHONE NO. (   ) (   ) (   )	FAX NO. (   ) (   ) (   )	
DATE BUSINESS WAS ESTABLISHED (Mo/Yr)	TYPE OF BUSINESS (Be specific)	E-MAIL ADDRESS	SIC CODE	
Has the company been insured by UNICARE in the last 12 months? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, date prior UNICARE coverage terminated: _____				
Has the employer filed for bankruptcy in the past seven years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No				

## 2. MEDICAL COVERAGE SELECTION

<input type="checkbox"/> All plans OR					
<input type="checkbox"/> Designate specific plan options (Check as many as apply)					
<b>High Option</b>		<b>Medium Options</b>		<b>Low Options</b>	
<input type="checkbox"/> UNICARE Premier No Deductible	<input type="checkbox"/> UNICARE 750	<input type="checkbox"/> UNICARE 500	<input type="checkbox"/> UNICARE 2000	<input type="checkbox"/> UNICARE 1000	<input type="checkbox"/> UNICARE Saver 1000

## 3. ADDITIONAL RIDER – Must complete.

<b>Mental Health - Check one:</b> <input type="checkbox"/> Add rider <input type="checkbox"/> Decline Rider	<b>Investigational Cancer Treatment - Check one:</b> <input type="checkbox"/> Add rider <input type="checkbox"/> Decline Rider
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## 4. DENTAL COVERAGE SELECTION

<input type="checkbox"/> All plans OR					
<input type="checkbox"/> Designate specific plan options (Check as many as apply)					
<b>High Options</b>		<b>Medium Options</b>		<b>Low Options</b>	
<input type="checkbox"/> High Option FFS	<input type="checkbox"/> High Option PPO	<input type="checkbox"/> Standard FFS	<input type="checkbox"/> Standard PPO	<input type="checkbox"/> Basic FFS	<input type="checkbox"/> Basic PPO

## 5. LIFE BENEFIT SELECTION – UNICARE Life and AD&D Benefit Schedule.

<input type="checkbox"/> <b>Option A</b> – \$15,000 Flat Amount for all employees
<input type="checkbox"/> <b>Option B</b> – Any Flat Amount higher than \$15,000, maximum \$250,000 \$ _____ (Must be in increments of \$5,000)
<input type="checkbox"/> <b>Option C</b> – Graded benefits by Job Title – <b>Class I:</b> Officers, managers, supervisors, \$30,000 – <b>Class II:</b> All other employees, \$15,000
<input type="checkbox"/> <b>Option D</b> – Graded benefits by Job Title – <b>Class I:</b> Officers, managers, supervisors, \$50,000 – <b>Class II:</b> All other employees, \$25,000
<input type="checkbox"/> <b>Option E</b> – Graded benefits by Job Title – <b>Class I:</b> Officers, managers, supervisors, \$100,000 – <b>Class II:</b> All other employees, \$50,000
<input type="checkbox"/> <b>Dependent Life Option:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

## 6. EMPLOYER CONTRIBUTION SELECTION

<b>6A. MEDICAL CONTRIBUTION SELECTION</b> Check one: <input type="checkbox"/> Defined Contribution 100* <input type="checkbox"/> Defined Contribution 80** <input type="checkbox"/> Defined Contribution Select*** \$ _____ <input type="checkbox"/> Traditional Contribution**** _____% <small>* Employer contributes \$100 per employee per month.          ** Employer contributes \$80 per employee per month.          *** Employer selects contribution amount over \$100 per employee per month in \$5 increments.          **** Employer selects contribution amount of 50% or more per employee per month.</small>	<b>6B. DENTAL CONTRIBUTION SELECTION</b> Check one: <input type="checkbox"/> Defined Contribution 15* <input type="checkbox"/> Defined Contribution Select** \$ _____ <input type="checkbox"/> Traditional Contribution*** _____% <small>* Employer contributes \$15 per employee per month.          ** Employer selects contribution amount over \$15 per employee per month in \$5 increments.          *** Employer selects contribution amount of 50% or more per employee per month.</small>	<b>6C. LIFE CONTRIBUTION SELECTION</b> <input type="checkbox"/> Employee Life Premium _____% <input type="checkbox"/> Dependent Life Premium _____%
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## 6D. SECTION 125 PREMIUM ONLY PLAN (P.O.P.) OPTION

<input type="checkbox"/> Check if you would like to enroll in P.O.P. (You must fully read the P.O.P. application booklet, complete the application form, and submit the completed form and separate enrollment check along with this Employer Application.) Administrative services provided by Ceridian Benefit Services, Inc., an independent company that is not owned or affiliated with any of the UNICARE companies, their affiliates, subsidiaries or parent company.
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FOR UNICARE USE ONLY					
DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS

**7. EMPLOYEE ELIGIBILITY**

Total number of employees (including owners): \_\_\_\_\_ Number of **ineligible** employees: \_\_\_\_\_  
Number of full-time (usually 30 hours per week) employees: \_\_\_\_\_ Number of **eligible** employees **declining** coverage: \_\_\_\_\_  
Total number of eligible **enrolling** employees including COBRA/FMLA applicants: \_\_\_\_\_

Are all eligible employees subject to withholding as on a W-2 form?  Yes  No – Please explain: \_\_\_\_\_

**Eligibility date is on the FIRST DAY of the month following the waiting period.**

Waiting period for future employees:  1 month  2 months  3 months

**The following to be completed by groups of 20 or more total employees and/or employer providing continuation of coverage in accordance with Title X of COBRA:** Is your group subject to COBRA?  Yes  No *If yes, please complete the COBRA/FMLA questionnaire.*

**The following question is to be completed by groups of 50 or more total employees and/or employer providing coverage in accordance with the Family and Medical Leave Act of 1993:** Is your group subject to FMLA legislation?  Yes  No *If yes, please complete the COBRA/FMLA questionnaire.*

**8. CURRENT CARRIER – Is this plan intended to replace any existing group coverage?**

**HEALTH:**  Yes  No If yes, name of group carrier: \_\_\_\_\_ Proposed termination date: \_\_\_\_\_  
**DENTAL:**  Yes  No If yes, name of group carrier: \_\_\_\_\_  
**LIFE:**  Yes  No If yes, name of group carrier: \_\_\_\_\_ Anniversary date: \_\_\_\_\_

**9. EFFECTIVE DATE – Actual effective date will be assigned by UNICARE underwriting department if policy is issued.**

Requested effective date: \_\_\_\_\_

**10. LEAVE OF ABSENCE**

A. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence:  
 None  1 month  2 months  3 months  4 months  
B. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence (maximum six months):  
 None  1 month  2 months  3 months  4 months  5 months  6 months

**11. MEDICAL INFORMATION**

To your knowledge:

1. Is any person to be covered unable to work due to injury or illness? .....  Yes  No  
2. Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? .....  Yes  No  
If yes to either question, provide names, dates, and degree of recovery: \_\_\_\_\_

**12. WORKERS' COMPENSATION**

Name of current Workers' Compensation carrier: \_\_\_\_\_ Renewal date: \_\_\_\_\_

Please list the name and job title of any person to be included as a subscriber under the UNICARE coverage who is not an employee, for the purpose of Workers' Compensation law or similar legislation. Please note that under Illinois law, partners and corporate officers, or members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances.

Name:	Title:	Exempt according to above requirements?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**13. SIGNATURE AND CONDITIONAL RECEIPT**

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA, apply to obtain the coverage indicated. We represent that all information on this Application is true and complete, and that UNICARE may rely on this Application in its decision to evaluate our group for eligibility and rating purposes. If not complete, UNICARE reserves the right to reject the Application and notify us in writing. We understand and agree that no coverage will be effective before the date determined by UNICARE. In addition, coverage will be effective only if we have paid our first month's premium and have met eligibility criteria. We understand that we will be informed of acceptance and effective date in writing if this Application is issued, that we should keep prior coverage in force until so notified and that no agent or broker has the right to accept Application or bind coverage. This Application becomes a part of our contract with UNICARE. **We verify that these answers are true and that coverage may be rescinded or reevaluated for eligibility and rating purposes should it be determined at a future date that there are misstatements in these Application forms. We have provided the individual or the person through whom the individual was eligible to be covered as a dependent prior to declining coverage with an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose at the time of the individual's later decision to elect coverage, an exclusion from coverage until the next open enrollment period as well as a preexisting condition exclusion for the lesser of twelve (12) months from the effective date or 18 months from the date of application, and received signed acknowledgement of the notice.**

**NOTICE: All doctors, hospitals and providers listed in the Directory of Providers are independent contractors. They are not agents or employees of UNICARE. When you or a covered member of your family select a Primary Care Physician or seek care from a network provider, either directly or by referral from another provider, you are seeking care from that provider, not from UNICARE. UNICARE does not control, nor does it have a right to control, any aspect of a provider's medical judgement. UNICARE's decisions about whether any medical service or supply is covered under your health plan are insurance benefit decisions only and are not the provision of medical care. UNICARE is not responsible for, does not provide, and does not hold itself out as a provider of, medical care. Only the doctors who treat you and your family can provide medical care, and only those doctors are responsible for any negligence in providing that medical care. If a service or supply is not eligible for benefits, you and your provider are free to proceed with that service or supply knowing that benefits are not available under your health plan.**

Dated at \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

By **X** \_\_\_\_\_ Title \_\_\_\_\_  
*(Signature of Company Officer / Owner)*

**14. CONDITIONAL RECEIPT – Agent, please photocopy and give to your client.**

This will acknowledge receipt of \$ \_\_\_\_\_ from \_\_\_\_\_ as a deposit against the insurance premiums that would become payable if UNICARE Life & Health accepts this Application for group coverage. This check will be held in trust by UNICARE pending acceptance or rejection of the Application. I have fully explained to the employer that in no event will benefits be payable for any loss incurred before the effective date assigned by UNICARE and that the company should retain any other coverage until then.

**15. AGENT'S CERTIFICATION**

- I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk.
- I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notification from UNICARE the coverage being applied for by this application is issued.

1. NAME OF WRITING AGENT (Print or Type)		%	AGENT TAX I.D. NO. (CHECK ONE)		<input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
AGENT ADDRESS		PHONE NO. (    )		FAX NO. (    )	
CITY / STATE / ZIP					
SIGNATURE OF AGENT <b>X</b>					DATE
2. NAME OF <input type="checkbox"/> SUB-AGENT <input type="checkbox"/> SECOND WRITING AGENT (Print or Type)		%	AGENT TAX I.D. NO. (CHECK ONE)		<input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
AGENT ADDRESS		PHONE NO. (    )		FAX NO. (    )	
CITY / STATE / ZIP					
SIGNATURE OF SECOND AGENT <b>X</b>					DATE
3. NAME OF GENERAL AGENT			AGENT NO. (TIN)		

