

5. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING FEWER THAN 15 EMPLOYEES AND FOR ALL LATE ENROLLEES

(Include information on all family members you wish to cover.)

All questions must be answered "yes" or "no." INCOMPLETE APPLICATIONS WILL BE REJECTED.

Within the time period indicated, has any person listed on this application consulted for, received medical advice for, been tested for, sought treatment for, had treatment recommended for, received treatment for (including any prescription medication), been hospitalized for or had any injury, impairment or illness related to or had any of the conditions listed below:

1. Within the last 10 years.
 - a. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, hyperlipemia, or arteriosclerosis Yes No
 - b. Ulcer, colitis, gallstone or hernia Yes No
 - c. Cancer, cyst, tumor, or growth Yes No
 - d. Diabetes Yes No
 - e. Tuberculosis, asthma, hay fever, adenoiditis or pleurisy Yes No
 - f. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for same Yes No
2. Within the last 5 years.
 - a. Epilepsy, fainting spells, mental or nervous condition or paralysis. If epileptic, date of last seizure: _____ Yes No
 - b. Arthritis, rheumatic fever, back trouble, or TMJ disorder Yes No
 - c. Any physical deformity or defect; serious bodily injury, fracture, concussion, burn and/or congenital problems, or any cosmetic surgery Yes No
 - d. Impairment or disease of the eyes or ears Yes No
 - e. Within the last 5 years, has any person to be covered had any impairment, illness, or departure from good health not listed in questions 1 and 2 above?..... Yes No
 - f. Within the last five years, had an x-ray, electrocardiogram, cardiovascular exam, or any laboratory test or study? Yes No
3. Other
 - a. Has any person to be covered ever had or been told they had an immune deficiency disorder, AIDS, or AIDS-related complex, or been diagnosed as HIV-positive? Yes No
 - b. Within the last 12 months, taking medications as prescribed by a physician or other health practitioner Yes No
 - c. Is any female to be covered currently pregnant or is any male expecting a child with anyone, whether listed on this application or not? Yes No
If yes, due date (Month/Day/Year) _____ Any history of complication of pregnancy?..... Yes No
 - d. Is anyone listed on this application currently in the process of adopting a child? Yes No
If yes, due date/adoption date (Month/Day/Year) _____
 - e. Does anyone listed on this application use tobacco products? Yes No

5A. IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING:

Please explain and provide us with **FULL DETAILS** for each "Yes" answer to any condition(s) checked in all the preceding boxes.

Include name of family member, nature of illness, dates and duration of treatment. (Attach additional sheets, if necessary.)

QUESTION #	NAME OF FAMILY MEMBER (As identified on Physician's Record)		NAME OF HOSPITAL, CLINIC, AND/OR PERSON PROVIDING CARE		PHONE NO. ()
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment	ADDRESS		SUITE NO.
NAME OF CONDITION/ILLNESS			CITY / STATE / ZIP CODE		FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS			MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE		
QUESTION #	NAME OF FAMILY MEMBER (As identified on Physician's Record)		NAME OF HOSPITAL, CLINIC, AND/OR PERSON PROVIDING CARE		PHONE NO. ()
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment	ADDRESS		SUITE NO.
NAME OF CONDITION/ILLNESS			CITY / STATE / ZIP CODE		FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS			MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE		
QUESTION #	NAME OF FAMILY MEMBER (As identified on Physician's Record)		NAME OF HOSPITAL, CLINIC, AND/OR PERSON PROVIDING CARE		PHONE NO. ()
DATE OF ONSET/TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment	ADDRESS		SUITE NO.
NAME OF CONDITION/ILLNESS			CITY / STATE / ZIP CODE		FAX NO. ()
TREATMENT RENDERED (i.e. X-ray, lab, surgery/procedure, etc.) / COMMENTS			MEDICATION (if taken) / DATE PRESCRIBED / DOSAGE		

6. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 15-50 EMPLOYEES:

	Yes	No
1. Within the last 5 years, has any person listed on this application, consulted for, received medical advice for, been tested for, sought treatment for, had treatment recommended for, received treatment for (including any prescription medication), been hospitalized for or had any injury, impairment or illness related to or had any of the conditions listed below? Cardiovascular disease or heart disorders; stroke; disorder of the kidney, stomach, intestines or liver; mental or nervous conditions; central nervous system disorders; diabetes; any disorders of the lungs or respiratory system; cancer or immune deficiency disorder, AIDS, or AIDS-related complex?	<input type="checkbox"/>	<input type="checkbox"/>
2. During the last 24 months, has any person listed on this application had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than \$5,000?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is any person listed on this application:		
a. Currently under treatment, receiving counseling or taking medicine for any condition or disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Currently pregnant, or is any male expecting a child with anyone, whether listed on this application or not? If yes, due date (Month, Day, Year) _____	<input type="checkbox"/>	<input type="checkbox"/>
c. A user of tobacco products within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
If you answer "Yes" to any of the above questions, complete the following: (Attach additional sheets, if necessary.)		
Name of patient: _____	Name of patient: _____	
Condition/Illness: _____	Condition/Illness: _____	
Dates of treatment: From _____ Through _____	Dates of treatment: From _____ Through _____	
Treatment rendered: _____	Treatment Rendered: _____	
Still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Still under treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medication and dosage taken: _____	Medication and dosage taken: _____	
Date: From _____ Through _____	Date: From _____ Through _____	
Treating provider's name/address: _____	Treating provider's name/address: _____	

7. OTHER MEDICAL COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS (All questions must be answered.)

1. Do any persons on this application intend to continue other Group coverage if this application is issued?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, name of person: _____ Insurance Co. _____ Policy No. _____		
2. Does any person applying for coverage currently have health insurance coverage?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, Proof of Coverage must be submitted. (See 7A below.)		
Has any person applying for coverage had health insurance coverage at any time in the past twelve (12) months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(Any Individual UNICARE coverage must be terminated if and when issued by this Group Medical Plan.)		
If yes, Name: _____ Type of coverage: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other (specify): _____		
Insurance Co: _____ Date coverage began: _____ Date ended: _____		
3. Does any person applying for coverage currently have Dental Insurance Coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, Type: _____ Insurance Co: _____ Date coverage began: _____ Date ended: _____		

7A. PROOF OF PRIOR COVERAGE (Required) – IMPORTANT

Proof of coverage should accompany this application. If a Certificate of Creditable Coverage is not received, it may subject you or a family member to the full pre-existing clause with no credit for prior coverage. You are entitled to a Certificate of Creditable Coverage from your prior carrier. UNICARE will assist in obtaining this information on your behalf should the need arise. Pre-existing conditions are conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the eligibility date; the exclusion extends for not more than 9 months and the exclusion is reduced by the aggregate of the periods of prior creditable coverage.

8. AUTHORIZATION *(The following Authorization is to be signed by all employees applying for coverage.)*

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage is issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours per week.

I understand that my eligible employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been received by UNICARE.

Any material or intentional misstatements or omissions may result in future claims being denied and the policy being re-evaluated for eligibility and rating purposes. Misstatements related to health status may not be used to void, cancel or non-renew this coverage.

I am applying for Participating Provider Plan coverage: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

Authorization to obtain or release Certificate of Creditable Coverage or medical information: I authorize my insurance company, physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this application to give UNICARE or its designated agent any and all records pertaining to any history of coverage, medical history, services or treatment provided to anyone listed on this application for purposes of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as necessary to permit evaluation of this application or to process claims, but not to exceed a period of two (2) years. A photocopy of this authorization is as valid as the original.

I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for that coverage has not been made by my employer.

I understand that I am entitled to a copy of this signed authorization if I request it.

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

SIGNATURE OF EMPLOYEE <i>(Required)</i>	TODAY'S DATE <i>(Required)</i>	SIGNATURE OF EMPLOYEE'S SPOUSE <i>(If applying for coverage)</i>	TODAY'S DATE <i>(Required)</i>
X		X	

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

