



2-50 Small Group Employer Application

Medical, Life, and Dental Coverage underwritten by UNICARE Life & Health Insurance Company

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	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)			
High Option	Medium Options	Low Options	
<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. DENTAL COVERAGE SELECTION

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

4. LIFE COVERAGE SELECTION – UNICARE Life and AD&D Benefit Schedule.

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

5. EMPLOYER CONTRIBUTION SELECTION

5A. MEDICAL CONTRIBUTION SELECTION 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**** _____% * 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.	5B. DENTAL CONTRIBUTION SELECTION Check one: <input type="checkbox"/> Defined Contribution 15* <input type="checkbox"/> Defined Contribution Select** \$ _____ <input type="checkbox"/> Traditional Contribution*** _____% * 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.	5C. LIFE CONTRIBUTION SELECTION <input type="checkbox"/> Employee Life Premium _____% <input type="checkbox"/> Dependent Life Premium _____%
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5D. 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.)
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DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS

6. 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.*

7. 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: _____

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

Requested effective date: _____

9. 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

10. 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: _____

11. 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 Indiana law, corporate officers are employees for Workers' Compensation purposes.

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

12. 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.**

Dated at _____ on the _____ day of _____ 20 ____.

By X _____ Title _____

(Signature of Company Officer / Owner)

13. 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 Life & Health and that the company should retain any other coverage until then.

14. AGENT’S CERTIFICATION

1. 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.			
2. 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 X			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 X			DATE
3. NAME OF GENERAL AGENT		AGENT NO. (TIN)	

