UNICARE Health Insurance Company of Texas
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 F

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)

UNICARE Use Only

Broker Number______ H/S ☐ Yes ☐ 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, 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 Health Insurance Company of Texas,
Administrative Office, P.O. Box 9063, Oxnard, CA 93031-9063

Section 4 – Health History

THIS SECTION MUST BE COMPLETED BY APPLICANT (If you are applying during open enrollment period or if you are eligible for guaranteed issue, you do not need to complete this section.)

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?	❑	❑
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?	❑	❑
3. Within the past 2 years, have you been advised to have surgery which has not yet been done?	❑	❑
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?	❑	❑
b. Alzheimer’s disease, Parkinson’s disease, senile dementia, organic brain disorder, or other senility disorder?	❑	❑
c. any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), or emphysema (excluding allergies and asthma)?	❑	❑
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?	❑	❑
5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	❑	❑

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

Do you now or have you during the past 5 YEARS used any tobacco products, including cigarettes, pipes, cigars, or chewing tobacco? ❑ Yes ❑ No

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 Health Insurance Company of Texas 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	
x	Date

Social Security Number	
Bank Name	
x	Date

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

Section 7 – Eligible Persons for Guaranteed Issue

The following describes the conditions for guaranteed issue. Please note specific time frames and evidence of term or disenrollment from a previous health plan may be required.

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

- Have you been terminated from or voluntarily disenrolled from an employee welfare benefit plan? ❑ Yes ❑ No

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

A. The certification of the organization or plan has been terminated; or

B. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

C. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

D. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

E. The individual meets such other exceptional conditions as the Secretary may provide.

- Have you been terminated from or voluntarily disenrolled from a Medicare+Choice plan or a Program of All-Inclusive Care for the Elderly (PACE)? ❑ Yes ❑ No

3. The individual is enrolled with an entity listed below and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2):

A. An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);

B. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

C. An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

D. An organization under a Medicare Select policy.

- Have you been terminated from or voluntarily disenrolled from an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), or a similar organization operating under demonstration project authority, or an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan), or an organization under a Medicare Select policy ? ❑ Yes ❑ No

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

A. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or of other involuntary termination of coverage or enrollment under the policy;

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

- Have your Medicare supplement policy enrollment ceases due to involuntary termination of coverage by the issuer, or the issuer substantially violated a material provision of the policy, or the issuer materially misrepresented the policy's provisions? ❑ Yes ❑ No

5. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

- Have you disenrolled from a Medicare supplement policy and subsequently disenrolled from a Medicare+Choice plan within 12 months of enrollment, for the first time? ❑ Yes ❑ No

6. The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare+Choice plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

- Have you disenrolled from a Medicare+Choice plan within 12 months of enrollment, for the first time? ❑ Yes ❑ No

Section 8 – Conditions of Application

Please read the following carefully.

1. 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.
2. 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 or during the period which I am an eligible person for guaranteed issue. 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.***
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.

Section 9 – Authorization and Agreements

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 reinstituted 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).

Authorization To Obtain or Release Medical Information–You Are Entitled To A Copy Of This Signed Authorization For Your Files If Requested.
(Read all five paragraphs and sign below)

■ I hereby authorize the 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, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of UNICARE Health Insurance Company of Texas any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.

■ I also authorize UNICARE Health Insurance Company of Texas, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.

■ This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable UNICARE Health Insurance Company of Texas to process claims. A photocopy shall be valid.

■ 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 Health Insurance Company of Texas coverage. Coverage will come into effect only if this application is approved by UNICARE Health Insurance Company of Texas.

■ I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

x ______________________________________ x ____________________

Applicant's Signature **Date of Signature**

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.

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: ❑ Agent ❑ Insured

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

Senior Services Toll-Free Number
Monday – Thursday: 7:30 a.m. to 4:30 p.m. (Central Standard Time)
Friday: 7:30 a.m. to 2:00 p.m. (Central Standard Time)
(800) 508-WELL–(800) 508-9355

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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.

Senior Services
Toll-Free Number

Monday – Thursday

7:30 a.m. to 4:30 p.m.

Friday

7:30 a.m. to 2:00 p.m.

(Central Standard Time)

(800) 508-WELL
(800) 508-9355

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 Health Insurance Company of Texas. 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. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy or certificate shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits.
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