

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: (818) 987-5000 (818) 776-9865

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction), or quarterly (every three months).

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

Oleg Skurskiy  
18375 Ventura Blvd. #226  
Tarzana , CA 91356

**Please make your check payable to: UniCare of Texas**

**We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.**

**If you have questions please contact our office at: (818) 987-5000**





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?   | <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

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

**Receipt for funds 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.

## 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

## Section 7 – Eligible Persons for Guaranteed Issue (continued)

- 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

### **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.

### **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).

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

Name

ID Number

Phone

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

**Entities or Persons Authorized to Receive:** UNICARE Health Insurance Company of Texas 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.

**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 Health Insurance Company of Texas  
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.

**Section 9 – Authorization and Agreements (continued)**

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** **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 \_\_\_\_\_  
**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.

■ 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**

**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.
- Fewer benefits and lower premiums.
- No change in benefits, but 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



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**

**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: _____	_____	Name: _____
Mo./Yr.		Address: _____
To: _____		City/State: _____
Mo./Yr.		

(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.*

**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	
<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)



**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

® Registered Mark of WellPoint Health Networks Inc.

0007566 TX 12/04

**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.**