

****Effective date of coverage will be the first of the month following receipt of the completed application. Please note:** Individuals newly eligible for Medicare may apply up to three months prior to their eligibility date for Medicare. Their enrollment date will be the same date as their Medicare effective date. Individuals submitting an application during the Annual Open Enrollment in November must choose an enrollment effective date of December or January.

2. HEALTH INFORMATION

- A. Do you have End-Stage Renal Disease (ESRD) or receive routine kidney dialysis treatment? Yes No

If you have ESRD or have not yet had a successful kidney transplant, you cannot enroll in UniCare SecurityChoice unless you are already enrolled as a member of a UniCare Health Plan, or if you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998. If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing that you don't need dialysis or have had a successful kidney transplant.

Your answers to the following health information questions will not affect your eligibility to enroll in UniCare SecurityChoice.

- B. Are you currently eligible for Medicaid (state assistance through the Department of Health and Human Services)? Yes No

If yes, Medicaid number: _____

- C. Are you currently a resident in a Medicare certified institution (such as a skilled nursing facility, rehabilitation hospital, etc.)? Yes No

If yes: _____

Name

Address

City/State/Zip

Phone Number of Institution: _____

Date of Admission into Institution: ___/ ___/ ___

- D. Do you or your spouse work? Yes No

- E. Do you, either on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or Veterans Administration benefits? Yes No

If yes, what kind of health insurance do you have?

Please provide the name of your insurance carrier: _____

Employer Name	Other Insurance Carrier Name
Policyholder Name	Policy Number
Other Carrier's Address (City, State, Zip)	

3. UNDERSTANDING YOUR RIGHTS AND RESPONSIBILITIES

I understand that the "effective date of coverage" referenced in section 1 of this application, is when I can begin using UniCare SecurityChoice services, and that UniCare will send me written notification of the effective date of my enrollment in UniCare SecurityChoice, usually the 1st of the month after receipt by UniCare. I understand that I should not cancel or drop any supplemental insurance I currently have until I receive written notice of my actual effective date from UniCare.

I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable.

I understand that I can be a member of only one Medicare Advantage (formerly known as Medicare+Choice) plan at a time, and that by enrolling in UniCare SecurityChoice, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage plan of which I am currently a member.

I understand that since I can be a member of only one Medicare Advantage plan at a time, I cannot enroll in UniCare SecurityChoice and another Medicare Advantage plan and have the same effective date of coverage. Doing so will cause my enrollments in both Medicare Advantage plans to be canceled and I will have to reapply to UniCare SecurityChoice.

I understand that it is my responsibility to inform UniCare prior to a permanent move out of the UniCare SecurityChoice service area or leaving the UniCare SecurityChoice service area for a temporary move of more than 6 months. My absence, under these two conditions, means that UniCare may take action to disenroll me from UniCare SecurityChoice and return me to traditional Medicare for medical coverage.

I understand that prior notification to UniCare is required for durable medical equipment, prosthetic devices and medical supplies costing more than \$750 and also for certain inpatient benefits, and that failure to notify UniCare when required may result in higher or additional out-of-pocket expenses for myself.

I understand that I must show my UniCare identification card, and agree to make every effort to give a Provider Disclosure form, to all health care providers prior to my receiving services so that they are aware of the terms and conditions of the plan.

I understand that I may disenroll from UniCare SecurityChoice by sending a written request to UniCare Member Services, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE (TTY/TDD: 1-877-486-2048). I understand that I must continue to show my Plan I.D. card prior to receiving services until UniCare informs me of the effective date of disenrollment.

I understand that as a member of UniCare SecurityChoice, I have the right to ask about the plan's decision about payment or services if I disagree.

I further understand and acknowledge the selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any UniCare coverage.

INITIAL: _____

4. ACKNOWLEDGEMENT

I understand that plan benefits, conditions, limitations and exclusions of coverage are detailed in the UniCare SecurityChoice Evidence of Coverage/Member Services Guide, which is given to me when I become a member.

INITIAL: _____

I have personally read and completed this application. I understand that receipt of money with this Enrollment Form does not create UniCare Coverage. Coverage will come into effect only if this application is approved by UniCare Life & Health Insurance Company. I, the applicant, acknowledge that I have read and understand the Enrollment Form in its entirety. If I am unable to sign this application, my court-appointed Legal Guardian, or person having General Durable Power of Attorney (GDPA) must sign this application.
(A copy of the proof of Legal Guardian or GDPA must be attached.)

X _____

**Applicant's Signature
(or signature of Legal Guardian or GDPA)**

_____/_____/____

Date of Signature

If you received assistance in filling out this application, please have the person helping you sign below:

X _____

**Signature of person who assisted
you with completion of this application**

Relationship to Applicant

Please refer to the UniCare SecurityChoice Evidence of Coverage/Member Services Guide for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

COMPLETE THIS FORM TO ENROLL IN THE OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION PROGRAM.

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 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 dues. 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 enclose a blank check marked "VOID".

Subscriber _____

Social Security Number _____

Group Number _____

Bank Name _____

x _____ **Date** _____

x _____ **Date** _____

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