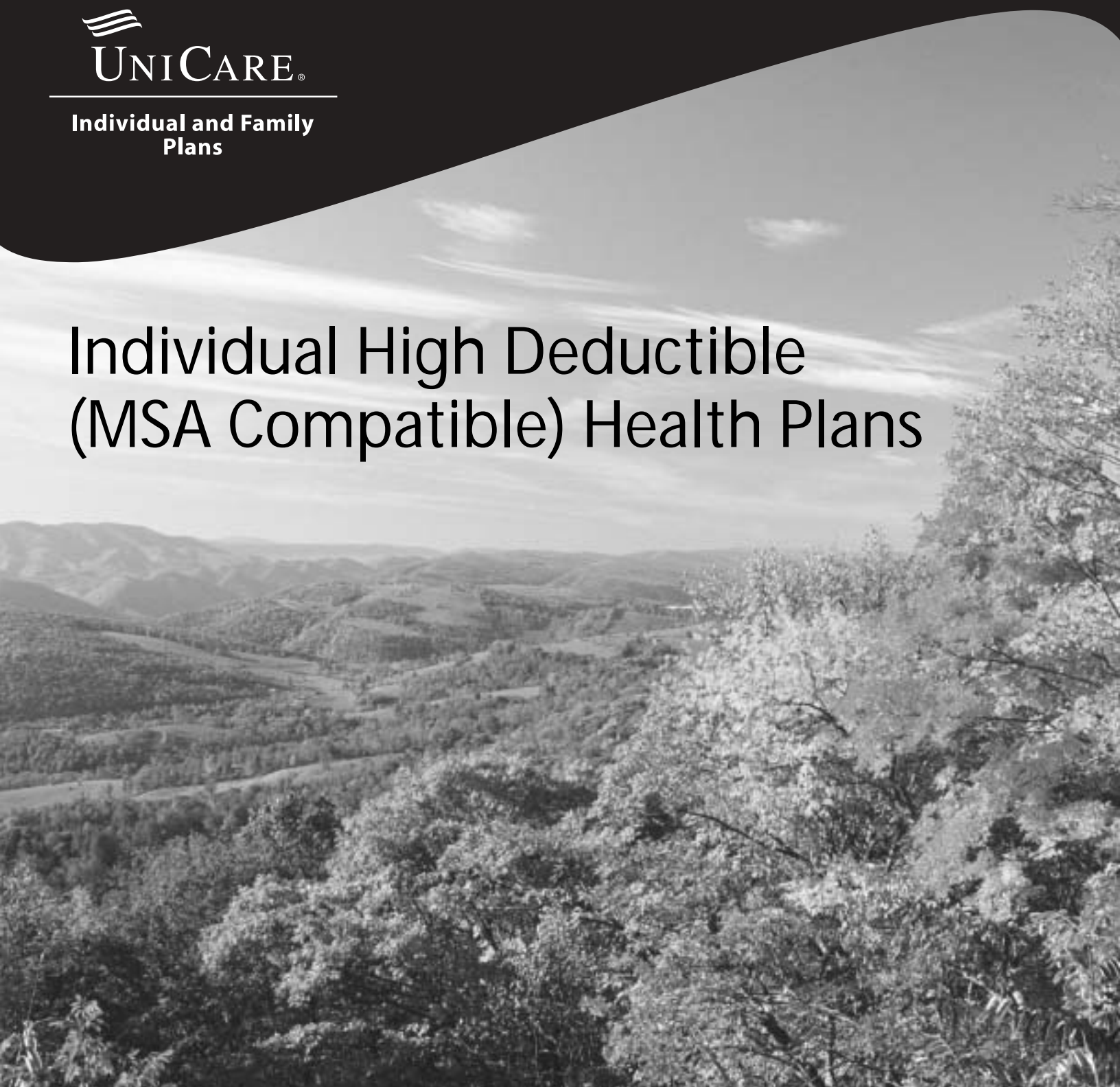


TEXAS



Individual and Family
Plans

Individual High Deductible (MSA Compatible) Health Plans



UNICARE offers MSA compatible

This is only a brief description of the plans. For complete details including benefits, limitations and exclusions, please refer to the applicable plan.

health plans so you can choose the right coverage for you and your family.

What Is a High Deductible (MSA Compatible) Health Plan?

An annual deductible is the amount you pay each year before your insurance plan begins to pay benefits for expenses covered by your health plan. A high deductible (MSA compatible) plan provides you with coverage for catastrophic medical occurrences that exceed the amount of your deductible. Since the premiums are usually lower on high deductible plans, you can deposit the money you save into an MSA to cover your lower cost, routine care.

What Is an MSA?

A Medical Savings Account (MSA) is a tax-favored account set up to pay for medical care and to allow for the build-up of savings to pay for future medical expenses.

In combination with a high deductible health insurance plan, it gives you a way to fund your health expenses now and save for long-term care expenses, or to bridge the gap caused by the uncertain future of Medicare.

The High Deductible (MSA Compatible) Health Plans are provided by UNICARE Life & Health Insurance Company (referenced herein as UNICARE). The Medical Savings Account is not administered by UNICARE and you may choose any MSA-qualified financial institution that provides this service.

UNICARE is a separately capitalized and incorporated subsidiary of WellPoint Health Networks Inc. WellPoint Health Networks Inc. is one of the largest managed care companies in the United States. WellPoint and its family of companies provide health coverage for over 13 million people and have over 42 million pharmacy customers. UNICARE's High Deductible (MSA Compatible) Plans provide:

- **Choice of doctors**
- **100% of covered expenses for UNICARE participating doctors once the deductible is satisfied**
- **Preventive care for children and adults**
- **Toll-free dedicated customer service numbers**
- **NO CLAIM FORMS with Network Providers**
- **Optional easy-issue Term Life Insurance**

Your Deductible Options

By law, the deductible for the health plan you choose directly affects the amount you may deposit into your MSA each year. UNICARE offers you the choice of a Single Party Plan (for you as an Individual) or a Family Plan for your family. You may choose a \$2,500 deductible for yourself or a \$4,950 deductible for yourself and your family. Individuals may deposit up to 65% of their deductible into their MSA each year, and families may deposit up to 75% of their deductible into their MSA each year, as shown in the table below.

<i>Your Plan</i>	<i>Deductible</i>	<i>Annual Amount You May Deposit in Your MSA</i>
Single Party	\$2,500.00 x 65% =	\$1,625.00
Family	\$4,950.00 x 75% =	\$3,712.50

In addition, your maximum allowable annual deposit is reduced proportionately if you were not covered under the High Deductible (MSA Compatible) Plan for the entire year. For example, if your plan goes into effect July 1, you can only contribute 50% of the respective maximum amount in that calendar year.

What Is the Advantage of Having the MSA?

Your UNICARE High Deductible (MSA Compatible) Plan pays benefits for certain covered medical services once your deductible is satisfied.

The funds you deposit into your MSA can be used to pay for these covered expenses.

There may be some other medical expenses not covered by this High Deductible Plan, such as cosmetic surgery or dental services, that you may be able pay for without penalty by using the funds deposited into your MSA. Please refer to section 213(d) of the IRS Code for information regarding what medical expenses can be covered by your MSA.

Eligibility

To enroll in a UNICARE High Deductible Plan, you must be eligible to open a qualified MSA.

UNICARE's determination of eligibility for coverage is not a determination that you are qualified to establish and/or maintain a Medical Savings Account. You should consult with your tax or legal advisor to determine if you are eligible under the law to establish and/or maintain an MSA.

Apply for Your UNICARE

High Deductible Plan Now

You must first enroll in a high deductible health plan before you can establish a Medical Savings Account. Because you must have a high deductible health insurance plan to open an MSA, *be sure you are accepted into the UNICARE Individual High Deductible (MSA Compatible) Health Plan BEFORE you open your MSA.* You must continue your enrollment in your high deductible plan in order to continue making contributions into your MSA.

UNICARE high deductible plans are not MSAs. The MSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. You must be an "eligible" individual under IRS regulations to receive the MSA tax benefits. The IRS has not yet issued MSA or high deductible health plan regulations or determined that UNICARE high-deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

UNICARE HIGH DEDUCTIBLE SINGLE PARTY AND FAMILY PLANS

These catastrophic medical plans provide quality coverage for eligible medical expenses both in and out of the hospital.

Benefit Summary

	Single Party Plan	Family Plan
Lifetime maximum benefit per member	\$5,000,000	\$5,000,000
Calendar year deductible	\$2,500	\$4,950 (per family)
Out-of-pocket maximum (includes calendar year deductible and out-of-network coinsurance)	\$3,300	\$6,050 (per family)

This is only a brief description of the plans. For more complete details, including benefits, conditions, limitations and exclusions, please refer to the applicable plan.

UNICARE Protects You From Catastrophic Expenses

For covered expenses when using UNICARE participating doctors and hospitals

You Pay

The amount of your calendar year deductible.

UNICARE Pays

100% of eligible charges after the deductible is satisfied.

For covered expenses when you use nonparticipating doctors and hospitals

You Pay

The amount of your calendar year deductible. Thereafter, you pay 25% coinsurance to a maximum additional out-of-pocket of \$800 for the Single Party Plan and \$1,100 for the Family Plan, plus any amounts over covered expenses.

UNICARE Pays

75% of eligible charges until your out-of-pocket maximum is reached, then 100% of covered expenses thereafter in a calendar year.

It Pays to Choose a UNICARE Participating Physician or Hospital

Example Only – Participating Providers

If billed charges for covered expenses are	\$1,000
and UNICARE's negotiated rate is	\$.650
you get a discount of	\$.350
If your deductible is met, UNICARE will pay 100% of this rate for total payment of	\$.650
Therefore you pay	\$.00

You will usually pay a significantly greater share of costs (out-of-pocket expenses) when you use a nonparticipating provider.

Your Share of Costs

The benefits outlined in the table on pages 4 and 5 show your share of payment for covered expenses after you have satisfied your deductible and prior to the coinsurance limit being reached. When you use UNICARE in-network (participating) providers, your costs are based on a specially negotiated rate for UNICARE that may often save you money. Remember that covered expenses may be significantly less than the actual billed charges when you use out-of-network providers. (Out-of-network covered expenses will be paid at the reasonable charge as determined by UNICARE.) Refer to the UNICARE provider directory, to determine which providers in your area are participating providers before you sign an application for coverage.

UNICARE Individual MSA High Deductible Plan – Summary of Benefits

Your Share of Costs for Covered Expense		
Your Plan Features	After payment of your annual deductible, when you use UNICARE providers, you pay:	After payment of your annual deductible, when you use non-UNICARE providers, we determine reasonable charges and of that you pay:
Professional services Office visits, surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic x-ray and lab	0	25% ¹
Preventive Care For Babies/Children (through age 6): Exam, lab Immunization For Adults: Routine Pap smears, annual mammograms, PSA for men, and the related exam	0 0 (annual deductible waived) 0	25% ¹ 0 (annual deductible waived) 25% ¹
Outpatient Medical Care ⁵	0	25% ¹
Physical/Occupational Therapy/Medicine	Charges over \$25 per visit, up to 12 visits per year.	
Acupuncture/Acupressure	Charges over \$25 per visit, up to 12 visits per year.	
Mental, Emotional or Functional Nervous Disorders (Excluding drug and alcohol abuse)		
Inpatient hospital charges ³	Charges over \$100 per day. (UNICARE pays up to \$3,000 per year.)	
In- or outpatient professional charges	Charges over \$25 per visit, up to 20 visits per year.	
Smoking Cessation	Charges over \$50 for pharmaceuticals per lifetime, per insured, and over \$50 for other covered services per lifetime, per insured, for any smoking cessation program.	
Infusion Therapy ⁴ (Administration of drugs and other substances through methods other than oral, such as chemotherapy through a vein.)	0	25% ¹
Durable Medical Equipment	0	25% ¹
Inpatient Hospital Services ³	0	25% ¹ and an additional \$500 deductible per continuing hospital confinement for non-emergency stays.
Surgery, x-rays, in-hospital doctor visits, organ/tissue transplant ⁶	0	25% ¹
Inpatient medical emergency ³	0	Nothing until no longer a medical emergency. Then 25% ¹ and a \$500 deductible per continuing hospital confinement.
Ambulatory Surgical Center ²	0	25% ¹
Ambulance Service	Charges over UNICARE's maximum covered expense of \$750 per trip (air or ground).	25% ¹ and charges over UNICARE's maximum covered expense of \$750 per trip (air or ground).
AIDS/ARC Treatment (Limit of \$10,000 per year, \$50,000 lifetime maximum)	0	25% ¹
Home Health Care ⁶ (Limit of 60 visits per year.)	0	25% ¹
Skilled Nursing Facilities ⁶ (Limit of 100 days per year.)	Charges over UNICARE's maximum covered expenses of \$400 per day	25% ¹ and charges over UNICARE's maximum covered expenses of \$400 per day
Hospice ⁶ (\$10,000 lifetime maximum)	0	25% ¹

Please refer to the section headed "Utilization Review/Authorization/Penalties" on the next page for an explanation of the footnotes.

Your Share of Costs for Covered Expense

Your Plan Features	Participating pharmacy, based on UNICARE negotiated rate, you pay:	Non-participating pharmacy, based on the average wholesale price of the drug, you pay:
Pharmacy		
Maximum 30-day supply		
Generic/Brand Name drugs	0	25% ¹

Utilization Review/Authorization/Penalties

This program provides you with valuable information about the medical necessity of services, helping you avoid both unexpected out-of-pocket costs and unnecessary procedures. Utilization review may take place prior to admission to a hospital or ambulatory surgical center, during a hospital stay, or following a discharge from a hospital or ambulatory surgical center. An important aspect of this program is preservice review. The following medical procedures must be reviewed for medical necessity through a preservice review: All non-emergency inpatient hospital stays, and non-emergency outpatient surgeries at an ambulatory surgical center. You must initiate a preservice review at least 3 working days prior to admission. There are penalties without a preservice review as described below.

- 1 In addition to the percentage of reasonable charges you pay, you must also pay any amounts above reasonable charges.
- 2 All surgical services of an ambulatory surgical center require preservice review or you pay an **additional \$50 penalty**. Ambulatory surgical centers must be licensed and accredited and meet all requirements of state and local laws and agencies.
- 3 Inpatient medical care has an **additional \$250 penalty** without preservice review. This penalty is waived on emergency admissions; however, utilization review is still required.
- 4 Infusion Therapy must be preauthorized by UNICARE. Covered expense includes professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment and training related to Infusion Therapy. It will not exceed: Total Parenteral Nutrition (with or without lipids), \$250 per day; Antibiotics, Average Wholesale Price (AWP) + \$125 per day; Chemotherapy, AWP + \$150 per day, Pain Management \$125 per day; Aerosol Therapy, AWP + \$70 per day; Tocolytic Therapy, \$250 per day; Special Items, AWP; Intravenous Hydration, \$75 per day. Failure to obtain authorization will result in an **additional \$500 penalty**.
- 5 Emergency room visits that do not result in inpatient admissions will require an **additional \$30 deductible**.
- 6 In addition to preservice review, you will pay an **additional \$500 penalty** unless UNICARE authorizes benefits. This applies to: Organ/Tissue Transplants, Infusion Therapy, Home Health Services, Skilled Nursing Facilities, and Hospice.

Additional Waiting Periods

An insured must be covered by the plan for 6 months to be eligible for payment for removal or treatment of hernia (except strangulated or incarcerated), hemorrhoids, varicose veins, disorders of the reproductive organs, sterilization, or disorders of tonsils or adenoids.

An insured person must be covered by the plan for 30 days prior to the inception of pregnancy to be eligible for any benefits for Complications of Pregnancy.

Pre-existing Conditions

For medical conditions that existed 12 months prior to the effective date of your coverage, there will be no coverage for such conditions for 12 months after the effective date of your coverage.

READ YOUR PLAN CAREFULLY. This summary of benefits provides a very brief description of the important features of your plan. This brochure is not the insurance contract and only the actual plan provisions will apply. The plan itself sets forth, in detail, the rights and obligations of both you and your insurance company. The terms of the Plan govern all benefit determinations. It is, therefore, important that you READ YOUR PLAN CAREFULLY!

Who Is Eligible to Apply for Coverage?

Self-employed individuals have the option of either a Single Party Plan or a Family Plan.

Single Party Plan

- You, if you're under age 64 1/2.
(No dependent coverage available)

Family Plan

To be eligible to apply for enrollment, you must be

- age 64 1/2 or younger
- the applicant's spouse, age 64 1/2 or younger
- the applicant's unmarried child and/or stepchild who has not yet reached age 25
- the applicant's unmarried grandchild who qualifies as a dependent of the applicant for federal income tax purposes at the time of application and who has not yet reached age 25
- a resident of the United States for at least six months
- able to meet UNICARE's underwriting requirements
- not eligible for Medicare
- not enrolled under any other Individual or Group health plan or insurance policy

Enrollment and Review Process

Each individual and family member who applies for coverage in any of the UNICARE plans must submit an application for UNICARE underwriting review. If any applicant does not qualify based on UNICARE's underwriting standards, the application will not be approved. Certain conditions, subject to UNICARE's underwriting guidelines, may qualify an applicant for the plan at a premium that is higher than the level I (preferred) premium and/or coverage for a particular medical condition may be excluded for coverage by a waiver. Waiting periods may apply for certain conditions. The pre-existing condition exclusion may apply for up to twelve months following the effective date of coverage. Please follow the instructions on the Individual and Family Plans application form.

Important Additional Information

10-Day Free Look

Once your plan arrives, you have 10 full calendar days to examine and either accept or decline by returning the plan.

Balanced Risk Keeps Your Costs Low

UNICARE believes in fairness. We believe the cost of covering someone with minimal health care needs

should not be unfairly offset by someone whose health can be predicted to require costly care. UNICARE maintains this risk balance by evaluating all individuals who apply for coverage with the same underwriting review criteria. If the applicant does not qualify for the particular coverage applied for, the application will be declined, approved with waivers, or approved with increased premium.

If you are accepted, please carefully read your UNICARE plan. This document lists in more detail all the benefits, conditions, limitations, exclusions, and requirements of your plan.

Waivers of Coverage

If you have a condition, illness, or injury that can be identified as one that does not necessarily affect your overall good health, but could affect the risk balance of all insureds, we will waive that condition from coverage. This means that expenses for treatment of that condition or any other condition related to it will not be covered for a specified period of time.

Waived conditions will be clearly identified on your plan specification page. The period for which coverage is waived will also be stated. Waivers apply for two years, five years, or ten years. Waivers will be reviewed periodically if you request the review in writing and forward the medical records from your attending physician.

Terms of Coverage

Coverage under this plan remains in force as long as the required premiums are paid on time and as long as the insured remains eligible for coverage. Coverage ceases when an insured becomes ineligible because of divorce or a change in dependent status. (In the case of divorce and over-age dependents, UNICARE may offer a similar plan.) UNICARE may change the premiums of this plan after 30 days written notice to the insured. However, UNICARE will not change the premium schedule for this plan on an individual basis, but only for all insureds in the same class and covered under the same plan as you.

Rates

Medical rates are calculated based on the age of the applicant or spouse, whoever is older, and the residence address. Rates are recalculated at each billing period based on age and the residence address. See pages 10-12 for medical coverage rates.

UNICARE Term Life Insurance (Optional coverage)

Coverage underwritten by UNICARE Life & Health Insurance Company

Life insurance provides a financial safety net for the people who depend on you. Once you qualify for a High Deductible Plan, you may also choose Term Life Insurance. For just a few cents more per day, you'll have the security and peace of mind that you can help meet your family's financial needs even if you're not there to provide for them. You may also choose life insurance for your eligible family members. It's as easy as checking a box on your application form and completing the Term Life Application Addendum on the last page of the brochure.

The rates for Term Life Insurance will change based on the applicant's age and the age categories shown in the chart below. The plan is issued for a one-year term, renewable at the subscriber's

option. The rate schedule may be changed at the beginning of any annual term.

The plan will be canceled automatically on the first day of the month of the subscriber's 65th birthday. If that birthday falls on the first of the month, the plan will be canceled on the first day of the month prior to the birth month.

The Term Life Insurance coverage is subject to the written provisions of the plan issued by UNICARE. Please refer to the plan for more complete details, including benefits, conditions, limitations and exclusions.

Each family member who has elected the Term Life Insurance option will be sent a separate plan.

Coverage Amounts	
Age	Amount
19 through 64	\$15,000
	25,000
	50,000
Under 19	\$15,000
	25,000
Under 1	Not available

Monthly Rates			
Age	\$15,000	\$25,000	\$50,000
1-18	\$1.50	\$2.50	N/A
19-29	2.80	4.65	9.30
30-39	3.25	5.40	10.80
40-49	7.50	12.50	25.00
50-59	20.90	34.80	69.60
60-64	29.40	49.00	98.00

Exclusions and Limitations

The primary limitations and exclusions for the plans described in this brochure are listed below. Please take a few moments to review this information. These listings are an overview only. A more detailed list of each plan's limitations and exclusions can be found in the applicable plan.

The plan does not provide benefits for:

- Services for any condition for which benefits are excluded by a waiver.
- Any amounts in excess of maximum amounts of covered expenses.
- Services not specifically listed in the plan as covered services.
- Services or supplies that are not medically necessary.
- Services or supplies that are experimental or investigative.
- Services received before the Effective Date of coverage or during an inpatient stay that began before that Effective Date.
- Services received after coverage ends.
- Services for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.
- Services received for any intentionally self-inflicted injury or illness.
- Services received for any condition caused by or contributed by (a) an act of war; (b) the inadvertent release of nuclear energy when government funds are available for treatment; (c) an insured person participating in the military service of any country; (d) an insured person participating in an insurrection, rebellion, or riot; (e) an insured person's commission of, or attempt to commit a felony; (f) an insured person, age 19 or older, being under the influence of illegal narcotics or non-prescribed controlled substances.
- Any services provided by a local, state or federal government agency except (a) when payment under the plan is expressly required by federal or state law; or (b) services provided for the treatment of mental or nervous disorders by a tax supported institution of the state of Texas.
- Any services to the extent that you are entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration hospitals and military treatment facilities will be considered for payment according to current legislation.
- Professional services received or supplies purchased from an insured person, a person who lives in the insured person's home or who is related to the insured person by blood, marriage, or adoption, or the patient's employer.
- Services of a private duty nurse.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy, or treatment of chronic pain; custodial care or rest cures. Services provided by a rest home, a home for the aged, a nursing home, or any similar facility service.
- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Treatment of mental, emotional, or functional nervous disorders (including a smoking cessation program) or psychological testing except as specifically stated in the plan.
- Treatment of drug, alcohol, or other substance addiction or abuse.
- Dental services.
- Orthodontic services.
- Dental implants or any associated procedures.
- Hearing aids.
- Routine hearing tests except as provided under well baby and well child care.
- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions.
- An eye surgery solely for the purpose of correcting refractive defects of the eye.
- Outpatient speech therapy.
- Any drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in the plan. This includes, but is not limited to, items dispensed by a physician.
- Cosmetic surgery or other services for beautification. This exclusion does not apply to medically necessary reconstructive surgery to restore a bodily function, to correct a deformity caused by injury or congenital defect of a newborn child, or by breast reconstruction performed to restore or achieve breast symmetry incident to a mastectomy.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.
- Treatment of sexual dysfunction or inadequacy.
- All services related to the evaluation or treatment of fertility and/or infertility, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals.
- All non-prescription contraceptive drugs and supplies and non-FDA approved prescription contraceptive drugs, devices, and supplies. Prescription contraceptive drugs or devices are covered under the prescription drug benefit of the plan.
- Charges for pregnancy and maternity care including but not limited to normal delivery, elective Cesarean sections, and elective abortions, except as specifically stated in the plan under *Complications of Pregnancy*.
- Cryopreservation of sperm or eggs.
- Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
- Services primarily for weight reduction or treatment of obesity including morbid obesity or any care which involves weight reduction as a main method for treatment.

- Routine physical exams or tests that do not directly treat an actual illness, injury, or condition, including those required by employment or government authority.
- Charges by a provider for telephone consultations. (Note: a Telemedicine Medical Service or Telehealth Service will not be excluded solely because the service is not provided through a face-to-face consultation.)
- Items which are furnished primarily for your personal comfort or convenience.
- Educational services except for a Diabetes Self-Management Training program and as specifically provided or arranged by UNICARE.
- Nutritional counseling or food supplements.
- Durable medical equipment not specifically listed in the plan.
- Any services received on or within twelve months after the effective date of coverage if they are related to a pre-existing condition.
- All Infusion Therapy together with any associated supplies, drugs or professional services except as specifically stated in the plan.
- All incidental supplies used by a provider in the administration of infusion therapy except where specifically stated in the plan.
- Self-administered injectable drugs, except as specifically stated in the prescription drug benefits section of the plan.
- Foreign country provider charges except as specifically stated in the plan.
- Growth hormone treatment.
- Routine foot care.
- Charges for which we are unable to determine our liability because you or an insured person failed within 60 days or as soon as reasonably possible to (a) authorize us to receive all the medical records and information we requested or, (b) provide us with information we requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a standby physician.
- Charges for animal to human organ transplants.
- Drugs and medications not requiring a prescription, except insulin.
- Non-medical substances or items, with the exception that pharmaceuticals to aid smoking cessation are covered up to a lifetime maximum payment of \$50 per insured person.
- Dietary supplements, cosmetics, and health or beauty aids.
- Any expense incurred in excess of the UNICARE negotiated rate.
- Any drug labeled “Caution, limited by federal law to investigational use” or non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications (such as progesterone suppositories).
- Syringes and/or needles, except those dispensed for use with insulin or other prescribed injectable medications.
- Professional charges in connection with administering, injecting, or dispensing of drugs.
- Drugs and medications dispensed or administered in an outpatient setting, including but not limited to, outpatient hospital facilities and doctors’ offices.
- Drugs used for cosmetic purposes.
- Drugs used for the primary purpose of treating infertility.
- Anorexiant.
- Drugs obtained outside the United States.
- Drugs for treatment of a condition, illness, or injury for which benefits are excluded or limited by a waiver, pre-existing condition, or other contract limitation.

Rating Area Definitions

AREA 1 RESIDENCE ZIP codes

770-772, 77401, 77402, 77411, 77413, 77423, 77429, 77433, 775 (except those ZIP codes listed in area 2)

AREA 2 RESIDENCE ZIP codes

77320, 77336-77349, 77357, 77362, 77365, 77372-77373, 77375, 77396, 77406, 77417, 77441, 77444, 77459, 77461, 77469, 77471, 77476-77479, 77481, 77487, 77489, 77496, 77497, 77510, 77517, 77518, 77519, 77539, 77545, 77546, 77549-77555, 77563, 77565, 77568, 77573, 77574, 77585, 77590-77592, 776, 777

AREA 3 RESIDENCE ZIP codes

752, 753, 773 (except those ZIP codes listed in area 2), 774 (except those ZIP codes listed in area 1 and area 2)

AREA 4 RESIDENCE ZIP codes

750 (except those ZIP codes listed in area 5), 75104, 75106, 75115, 75116, 75123, 75134, 75137, 75138, 75141, 75146, 75149, 75150, 75159, 75172, 75180-75182, 75185, 75187, 760 (except those ZIP codes listed in area 5), 761

AREA 5 RESIDENCE ZIP codes

733, 75009, 75020, 75021, 75058, 75069, 75070, 75076, 75090-75092, 75097, 751 (except those ZIP codes listed in area 4), 756-759, 76023, 76028, 76031-76033, 76041, 76043, 76048-76050, 76055, 76070, 76073, 76077, 76078, 76084, 76086-76088, 762, 778, 779, 782-787, 789, 791

AREA 6 RESIDENCE ZIP codes

All ZIP codes beginning with 754, 755, 763-769, 780, 781, 788, 790, 792-799, 885

Certain medical conditions

For certain medical conditions, an applicant may qualify for a plan at a premium that is higher than Level 1 rates.

Tobacco users

Tobacco users pay an additional 20 percent premium. If any family member who is to be insured uses tobacco, see the Level 1+20 percent rates.

Additional Information

- Rates are based on the age of the applicant or spouse, whoever is older, and the residence address. Rates are recalculated at each billing period based on age and the residence address.
- Payment methods are
 - 1) monthly by checking account deduction on the first of each month or
 - 2) 3-month (quarterly) billing.

Nonrefundable \$25 Application Fee

- Must be submitted with the completed application and first month's premium
- May be paid by a separate credit card transaction
- If paying by check, a separate check is required
- Only one fee is required for families submitting more than one application at the same time, in the same envelope

See Application Instructions for specifics.

Texas Individual High Deductible (MSA Compatible) Monthly Rates Level 1

The Single Party Plan Deductible is \$2,500. The Family Plan Deductible is \$4,950.

Rating Group	Age Range	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single Male	Under 30	79	70	67	64	59	54
	30-34	86	76	73	70	65	58
	35-39	95	84	81	77	71	65
	40-44	116	102	99	94	87	79
	45-49	142	125	121	115	107	97
	50-54	161	142	137	130	121	109
	55-59	218	192	185	177	164	148
	60-64	287	253	244	232	215	195
Single Female	Under 30	90	79	77	73	68	61
	30-34	104	92	88	84	78	71
	35-39	121	106	103	98	91	82
	40-44	141	124	120	114	106	96
	45-49	161	142	137	130	121	109
	50-54	196	172	167	159	147	133
	55-59	218	192	185	177	164	148
	60-64	257	226	218	208	193	175
Subscriber & Spouse	Under 30	142	125	121	115	107	97
	30-34	150	132	128	122	113	102
	35-39	168	148	143	136	126	114
	40-44	201	177	171	163	151	137
	45-49	241	212	205	195	181	164
	50-54	274	241	233	222	206	186
	55-59	356	313	303	288	267	242
	60-64	439	386	373	356	329	299
Subscriber & 1 Child	Under 30	137	121	116	111	103	93
	30-34	151	133	128	122	113	103
	35-39	168	148	143	136	126	114
	40-44	188	165	160	152	141	128
	45-49	208	183	177	168	156	141
	50-54	243	214	207	197	182	165
	55-59	265	233	225	215	199	180
	60-64	334	294	284	271	251	227
Subscriber & 2 Children	Under 30	185	163	157	150	139	126
	30-34	199	175	169	161	149	135
	35-39	216	190	184	175	162	147
	40-44	236	208	201	191	177	160
	45-49	257	226	218	208	193	175
	50-54	291	256	247	236	218	198
	55-59	314	276	267	254	236	214
	60-64	382	336	325	309	287	260
Subscriber & 3+ Children	Under 30	232	204	197	188	174	158
	30-34	246	216	209	199	185	167
	35-39	263	231	224	213	197	179
	40-44	283	249	241	229	212	192
	45-49	304	268	258	246	228	207
	50-54	338	297	287	274	254	230
	55-59	361	318	307	292	271	245
	60-64	429	378	365	347	322	292
Family & 1 Child	Under 30	189	166	161	153	142	129
	30-34	197	173	167	160	148	134
	35-39	215	189	183	174	161	146
	40-44	248	218	211	201	186	169
	45-49	288	253	245	233	216	196
	50-54	321	282	273	260	241	218
	55-59	403	355	343	326	302	274
	60-64	486	428	413	394	365	330
Family & 2 Children	Under 30	237	209	201	192	178	161
	30-34	245	216	208	198	184	167
	35-39	263	231	224	213	197	179
	40-44	296	260	252	240	222	201
	45-49	337	297	286	273	253	229
	50-54	370	326	315	300	278	252
	55-59	451	397	383	365	338	307
	60-64	535	471	455	433	401	364
Family & 3+ Children	Under 30	284	250	241	230	213	193
	30-34	292	257	248	237	219	199
	35-39	310	273	264	251	233	211
	40-44	343	302	292	278	257	233
	45-49	384	338	326	311	288	261
	50-54	417	367	354	338	313	284
	55-59	498	438	423	403	374	339
	60-64	582	512	495	471	437	396

Non-refundable \$25 Application Fee Required: A separate, non-refundable \$25 application fee must be submitted with each application and the first month's premium. The fee may be paid by separate check or credit card charge. Only one fee is required for families submitting separate applications at the same time, in the same envelope. Application fee effective 2/1/02.

Texas Individual High Deductible (MSA Compatible) Monthly Rates Level 1+20

The Single Party Plan Deductible is \$2,500. The Family Plan Deductible is \$4,950.

Rating Group	Age Range	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single Male	Under 30	95	84	80	77	71	65
	30-34	103	91	88	84	78	70
	35-39	114	101	97	92	85	78
	40-44	139	122	119	113	104	95
	45-49	170	150	145	138	128	116
	50-54	193	170	164	156	145	131
	55-59	262	230	222	212	197	178
	60-64	344	304	293	278	258	234
						562	509
Single Female	Under 30	108	95	92	88	82	73
	30-34	125	110	106	101	94	85
	35-39	145	127	124	118	109	98
	40-44	169	149	144	137	127	115
	45-49	193	170	164	156	145	131
	50-54	235	206	200	191	176	160
	55-59	262	230	222	212	197	178
	60-64	308	271	262	250	232	210
						457	414
Subscriber & Spouse	Under 30	170	150	145	138	128	116
	30-34	180	158	154	146	136	122
	35-39	202	178	172	163	151	137
	40-44	241	212	205	196	181	164
	45-49	289	254	246	234	217	197
	50-54	329	289	280	266	247	223
	55-59	427	376	364	346	320	290
	60-64	527	463	448	427	395	359
						722	655
Subscriber & 1 Child	Under 30	164	145	139	133	124	112
	30-34	181	160	154	146	136	124
	35-39	202	178	172	163	151	137
	40-44	226	198	192	182	169	154
	45-49	250	220	212	202	187	169
	50-54	292	257	248	236	218	198
	55-59	318	280	270	258	239	216
	60-64	401	353	341	325	301	272
						604	547
Subscriber & 2 Children	Under 30	222	196	188	180	167	151
	30-34	239	210	203	193	179	162
	35-39	259	228	221	210	194	176
	40-44	283	250	241	229	212	192
	45-49	308	271	262	250	232	210
	50-54	349	307	296	283	262	238
	55-59	377	331	320	305	283	257
	60-64	458	403	390	371	344	312
						647	587
Subscriber & 3+ Children	Under 30	278	245	236	226	209	190
	30-34	295	259	251	239	222	200
	35-39	316	277	269	256	236	215
	40-44	340	299	289	275	254	230
	45-49	365	322	310	295	274	248
	50-54	406	356	344	329	305	276
	55-59	433	382	368	350	325	294
	60-64	515	454	438	416	386	350
						690	625
Family & 1 Child	Under 30	227	199	193	184	170	155
	30-34	236	208	200	192	178	161
	35-39	258	227	220	209	193	175
	40-44	298	262	253	241	223	203
	45-49	346	304	294	280	259	235
	50-54	385	338	328	312	289	262
	55-59	484	426	412	391	362	329
	60-64	583	514	496	473	438	396
						766	694
Family & 2 Children	Under 30	284	251	241	230	214	193
	30-34	294	259	250	238	221	200
	35-39	316	277	269	256	236	215
	40-44	355	312	302	288	266	241
	45-49	404	356	343	328	304	275
	50-54	444	391	378	360	334	302
	55-59	541	476	460	438	406	368
	60-64	642	565	546	520	481	437
Family & 3+ Children	Under 30	341	300	289	276	256	232
	30-34	350	308	298	284	263	239
	35-39	372	328	317	301	280	253
	40-44	412	362	350	334	308	280
	45-49	461	406	391	373	346	313
	50-54	500	440	425	406	376	341
	55-59	598	526	508	484	449	407
	60-64	698	614	594	565	524	475

Non-refundable \$25 Application Fee Required: A separate, non-refundable \$25 application fee must be submitted with each application and the first month's premium. The fee may be paid by separate check or credit card charge. Only one fee is required for families submitting separate applications at the same time, in the same envelope. Application fee effective 2/1/02.

Individual & Family High Deductible (MSA Compatible) Plans Life and Dental Plans Application



Individual and Family
Plans

Thank you for applying with UNICARE.

PLEASE NOTE:

- **Coverage is not available if:**
 - any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
 - the applicant has not resided in the U.S. for the last six (6) consecutive months.
- **Coverage is not guaranteed until approved in writing by UNICARE. Do not cancel your current insurance coverage until you have been notified of approval by UNICARE and your UNICARE coverage is effective.**

Instructions

Do not complete this application until you have read the current product brochure.

Please follow these instructions to allow us to better process your application.

- For your own protection, **you, the applicant**, must complete this application. You are solely responsible for its accuracy and completeness.
- All information must be stated accurately.
- All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
- For additional information or explanations attach extra sheets, if necessary. **All attachments must be signed and dated.**
- Print clearly using blue or black ink. No correction fluid, please. **Sorry, but typed applications will not be accepted.**
- This application must be received by UNICARE Medical Underwriting within thirty (30) days from the signature date.
- UNICARE Health and Dental Plans are available only in areas where the UNICARE Network exists. Please see Provider Directories for more details.
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the plan being rescinded.
- Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Section 7 – Conditions of Application).**
- Please return this application and your check to your agent OR mail to the address listed at right.
- **Also please include a separate \$25 non-refundable application fee.** Only one application fee is required for families submitting more than one application at the same time in the same envelope. The application fee is waived for all applications submitted online.

Insurance coverage underwritten by UNICARE Life & Health Insurance Company
a separately capitalized and incorporated subsidiary of WellPoint Health Networks Inc.
® Registered Mark of WellPoint Health Networks Inc.

Billing Information

Carefully read the instructions accompanying each billing type and make sure that your check is attached to the application.

- **Monthly billing (with monthly bank draft authorization only):** Submit the one (1)-month premium, complete the Monthly Bank Draft Authorization.
- **Quarterly billing:** Submit the three (3)-month (quarterly) premium.

Most common causes for delay in underwriting

- Missing, inaccurate or incomplete information such as:
 - Weight AND Height
 - Spouse's social security number
 - Dependent's social security number
 - Date of birth
 - Date of last pelvic examination
 - Results of last pelvic examination
 - Physician address, phone number and fax number
- Incomplete or illegible information such as the mailing address does not include city, state, and ZIP code.
- ALL questions are not answered in Sections 4 and 6. If it does not apply to you, the answer should be "No." Do not leave any answers blank.
- The application is not signed and dated by the applicant and/or all dependents over age 18.
- Agent portion of application is not completed, signed, or dated with a date on or after applicant's signature date.
- Additional documentation or information is required.
- Failure to include a **separate** \$25 non-refundable application fee check.

Mailing Address

- **Applicant:** Please return this application to the agent.
- **Agent:** Please mail this application to the address below.

UNICARE Life & Health Insurance Company
Attn: Individual Services - Texas
P.O. Box 5030
Bolingbrook, IL 60440-5030



Individual Enrollment Application - Texas

Applicant's Social Security No.									

UNICARE Life & Health Insurance Company

- Application must be completed by the applicant in blue or black ink.
- Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.

1. Applicant Information (Please Print)

Primary Applicant's Last Name	First Name	M.I.
Home Address (Residence address required; P.O. Box not acceptable)		
City	State	ZIP Code

Reason for Application (Check one)

- New Enrollment(s)
 Child only (Please use youngest child for primary applicant)
 Add dependent(s) to I.D. No: _____
 To change existing UNICARE plan, please enter I.D. No:

For Summary Bill (existing), I.D. No: _____

Mailing Address (If different than above)	(P.O. Box or Personal Mail Box No.)	Home Phone No. () ()	E-mail Address (Optional)
City	State	ZIP Code	Daytime Phone No. () ()
In care of:		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Spouse's Social Security No. (Required)
Billing Type:	<input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Quarterly Billing <input type="checkbox"/> Summary Bill (Please attach Summary Bill cover sheet.)	Maiden Name of Applicant / Spouse (if applicable)	
Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name and explain:			
Language preference (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Polish <input type="checkbox"/> Other (Specify):			
Ethnic Code (Optional)			
1 <input type="checkbox"/> Caucasian	3 <input type="checkbox"/> Black/African American	5a <input type="checkbox"/> Native American Indian	A <input type="checkbox"/> Amerasian
2 <input type="checkbox"/> Hispanic	4 <input type="checkbox"/> Asian	5b <input type="checkbox"/> Alaskan Native	C <input type="checkbox"/> Chinese
		7 <input type="checkbox"/> Filipino	H <input type="checkbox"/> Cambodian
			J <input type="checkbox"/> Japanese
			K <input type="checkbox"/> Korean
			M <input type="checkbox"/> Samoan
			N <input type="checkbox"/> Asian Indian
			P <input type="checkbox"/> Hawaiian
			R <input type="checkbox"/> Guamanian
			T <input type="checkbox"/> Laotian
			V <input type="checkbox"/> Vietnamese
			Z <input type="checkbox"/> Other

2. Choice of UNICARE Individual Coverage

Plan Choice:	<input type="checkbox"/> High Deductible (MSA Compatible) Single Party Plan (H033)	<input type="checkbox"/> Life
	<input type="checkbox"/> High Deductible (MSA Compatible) Family Plan (H034)	<input type="checkbox"/> Dental

3. Applicants for Coverage

Check one: Insure all eligible applicants Insure no one unless all are accepted for coverage

Please list all applicants applying for coverage. (List children youngest to oldest)

If a family member's last name is different than yours, please attach explanation to application.

Relation	Last Name	First Name	M.I.	MUST BE ACCURATE		Date of Birth	Social Security No.	✓ Dental	UNICARE USE ONLY	
				Height	Weight				WVR	WVR
<input type="checkbox"/> Male <input type="checkbox"/> Female	Yourself									
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										

FOR UNICARE USE ONLY - DO NOT WRITE BELOW

Group No.	Certificate No.	Agent I.D. No.	Effective Date	X Ref. Cert. No.	<input type="checkbox"/> AA <input type="checkbox"/> AR
By	Date				

4. Other Coverage - Please answer all of the following questions.

A. Do you currently have, or has anyone to be insured had coverage in the last 18 months? Yes No

If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

Name of insured	Insurance carrier(s)	Effective date	End date
-----------------	----------------------	----------------	----------

Do you agree to discontinue your current coverage if this application is accepted? Yes No

If No, please explain:

B. Has anyone on this application been insured by UNICARE in the last 5 years? Yes No

If Yes, please provide the following information.

Name of insured	Plan/I.D. No.	Group No.	
Name of Plan	City	State	Date cancelled

C. If any applicant has/had UNICARE group coverage, please complete the following:

I certify that my UNICARE group coverage will end/ended on (date):

I do not wish to enroll in any available Conversion Agreement. I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.

D. Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? Yes No

If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain
3. Name of applicant	Name of Insurance Company	Explain

E. Are any persons applying for coverage on this application eligible for Medicare benefits? Yes No

If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.

Eligible person(s)

F. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? Yes No

If Yes, please provide the following information.

Name of applicant	Effective date	End date
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5. Term Life Insurance

Applicants must meet UNICARE'S Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. **Submit Premium with application.**

Name of Family Member	✓ Amount of Coverage			Name of Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP Code
	\$15,000	\$25,000	\$50,000*			
Primary Applicant						
Spouse						
Dependent						

*The \$50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to \$25,000.

**If a beneficiary is not listed and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

I have discussed Life Insurance with my agent and decline to apply – Initial: _____

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6. Health History – Include information on all family members you wish to enroll.

6A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.

Has any person listed on this application had a clear, distinct symptom that would cause an ordinarily prudent person to seek advice or treatment, or had treatment recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **within the last 10 years**:

<p>1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis, or any other neurological or central nervous system disorder(s) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>18. Male applicant(s) a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, or implant <input type="checkbox"/> Yes <input type="checkbox"/> No b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy, or any similar symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>19. Female applicant(s) a) Breast disorder/cyst, lump, fibroid tumors, silicone injections, or implants <input type="checkbox"/> Yes <input type="checkbox"/> No b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No c) Date and result of last pelvic exam/Pap smear for each female over 16: Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal d) Is the applicant, spouse or any female dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, or any other circulatory condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>21. Diseases or problems of the ears or hearing, implant, or hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, or use of a sleep monitoring device <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, or any other digestive disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Has any person listed on this application ever: 25. Had cancer, tumor/growth, leukemia, or cyst? <input type="checkbox"/> Yes <input type="checkbox"/> No 26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery, or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain, or hepatitis (indicate type: _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor, or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>28. Been diagnosed as having or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio, or any other musculoskeletal disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation, or prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>13. Diabetes, thyroid, pituitary, adrenal, or any other endocrine disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>15. Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery, or any other skin conditions <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>17. Sexually transmitted disease, such as herpes, genital warts, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

IMPORTANT: Applicant's medical conditions, which occur after the signature date and before the approval date that come to UNICARE's attention, may be considered in the final underwriting decision.

6B. Professional Services

Applicant's Social Security No.									

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Still under treatment		Medications			Frequency	
If abnormal, please explain:			Dosage	Date Prescribed	Date Discontinued	

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Still under treatment		Medications			Frequency	
If abnormal, please explain:			Dosage	Date Prescribed	Date Discontinued	

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Still under treatment		Medications			Frequency	
If abnormal, please explain:			Dosage	Date Prescribed	Date Discontinued	

6C. Prescription Medications –

List all medications not noted above taken within the last 12 months by any family member listed on this application.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued	Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/ZIP Code

6D. Other Health Questions

1. Has any applicant ever smoked or used any tobacco products, such as: cigarettes, cigars, pipe, snuff, or chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member	Amount per day	2. Family member	Amount per day
	Type of product	Date Discontinued	Type of product	Date Discontinued
2. Has any applicant used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, in the last 10 years, or been diagnosed as chemically or alcohol dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant ever used any illegal or controlled I.V. drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has any applicant consumed any alcoholic beverages in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.</i>	1. Family member		2. Family member	
	Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month		Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member	Date Discontinued	2. Family member	Date Discontinued

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. No. of sheets attached

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7. Conditions of Application

It is important that you carefully read and fully understand the following.

Applicant's Social Security No.

I, the undersigned, understand that, under the UNICARE plan for which I am applying, I may be entitled to lesser benefits if I use a non-participating hospital, physician, or other provider, than if I use a UNICARE independently contracted participating hospital, physician, or other provider.

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section 10, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If, however, you would like to request a specific effective date, we strongly recommend you allow 60-75 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance, and will prevent you from being required to pay for two policies.

NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.

- I request that UNICARE assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.
- If UNICARE approves my application, please assign an effective date of the
 - 1st of the month following approval.
 - 15th of the month following approval.
 - 1st of _____ 15th of _____.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, ONLY UNICARE CAN CHANGE THIS DATE, HOWEVER, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE PLAN IS ISSUED.

Initial X

Billing Date

UNICARE premiums are due on the 1st of each month. Insureds with a mid-month premium effective date will be billed on a pro-rated basis to bring future due dates to the first of a month.

Agreement (All applicants)

I, the undersigned, agree to the following:

1. I understand and agree to pay a non-refundable application fee of \$25 to be paid on a separate check or through a separate credit card deduction and to pay the premium amount required with this application. If my application is denied, UNICARE will return only the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.
2. If my application for UNICARE coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by UNICARE that my application is approved.
3. I understand that UNICARE has the right to deny my application, and if it does so, I will be notified in writing and the premium I submitted will be returned.
4. **MINOR CHILDREN:** I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.
5. **CONCERNING DEPENDENTS AGE 18 AND OVER:** I represent that my dependents age 18 and over (1) have read this application, and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, especially Sections 6A, 6B, 6C and 6D with them, and (3) all information contained in this application regarding them is complete and accurate.
6. I understand and agree that if UNICARE rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Receipt of money, and/or cashing of my

non-refundable application fee check or cashing of my premium check or charging either of these amounts to my credit card by UNICARE does not constitute approval of my application or create UNICARE coverage.

7. If I am accepted, this application will become part of the agreement between UNICARE and myself.
8. UNICARE may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, UNICARE will determine payment, and I will be responsible for any difference.
9. The selling agent has no authority to promise me coverage or to modify UNICARE underwriting policy or terms of any UNICARE coverage.
10. I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. UNICARE may void all coverage from the original effective date of the agreement for such material misstatements or omissions.
If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.
PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.
11. My UNICARE agent may receive copies of any correspondence about my medical history when correspondence is required.

Authorization

I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide UNICARE, its agents, or employees, including my UNICARE agent or broker, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below for a period not longer than two (2) years. A photocopy of this Authorization is as valid as the original. My authorized representative, UNICARE agent, or I am entitled to receive a copy of this form.

I understand and agree to all the Conditions of Application (Section 7). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 11). I have read and understand this Application in its entirety. I have received a written plan description.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse (required if applying for coverage)	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

ATTACH INITIAL PREMIUM CHECK
AND SEPARATE CHECK FOR
APPLICATION FEE HERE.
DO NOT TAPE.

Applicant's Social Security No.
| | | | | | | | | | | |

8. Payment Method – Submit non-refundable application fee and premium payment with application (required).

8A. Non-Refundable \$25 Application Fee Payment
Only one application fee is required for families submitting more than one application at the same time. No application fee is required for applications submitted online.

Please charge the separate, non-refundable application fee to my credit card. I am attaching a separate check for the non-refundable application fee.

Initial Premium Payment by Credit Card

New members only. Not available to make a coverage change.

Select one: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	Initial Premium Amount \$	Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard	Credit Card No.	Expiration Date
Cardholder's Name	Cardholder's ZIP Code	Authorized Signature (as it appears on the credit card) X	Today's Date	

8B. Payment Type (First payment will be credited to approved applicants only.)

Monthly Billing (Available with Monthly Checking Account Deduction).

Quarterly Billing

- Submit the one (1) month premium.
- Complete section 8C, **Monthly Checking Account Deduction Authorization**.
- If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account on the first of the month ONLY.

8C. Monthly Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated. If the account listed below is a joint account, both account holders' signatures are required. **UNICARE must be notified of any changes to your bank account no later than the 20th of the month preceding the change.**

AUTHORIZATION: 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 with respect to each debit will 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 premium. 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 debit. I further agree that if any such debit 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.

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

You will incur a \$25 service charge for any withdrawal not honored.

Applicant Name	Applicant Social Security No.	Name on Checking Account		
Name of Bank or Financial Institution	Address	City	State	ZIP Code
Checking Account No.	Bank Routing No.	Federal Credit Union Routing No.		
Authorized Signature (as it appears in the financial institution's records)	Date	Authorized Signature (as it appears in the financial institution's records)	Date	

(Continued on reverse)

DETACH HERE

DO NOT WRITE BELOW

Applicant's Social Security No.									

9. To be completed by your UNICARE-Appointed Agent

<ul style="list-style-type: none"> ■ Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk?.. <input type="checkbox"/> Yes <input type="checkbox"/> No ■ Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____ 	<ul style="list-style-type: none"> ■ Breakdown of funds collected: Total Medical premium \$ _____ Total Dental premium \$ _____ Total Life premium \$ _____ Non-refundable application fee \$ \$25 Total funds collected \$ _____
<ul style="list-style-type: none"> ■ I verify that this application was completed by the applicant unless the Statement of Accountability (Section 10) was completed..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	<ul style="list-style-type: none"> ■ Was the Monthly Checking Account Deduction Authorization (Section 8C) completed? (only if applicable)..... <input type="checkbox"/> Yes <input type="checkbox"/> No ■ Was a Conditional Receipt given? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Agent (Print Name)		Agent's Street Address/Suite or Personal Mail Box No.	
Agent I.D. No.	Sub-Agent I.D. No.	City/State/ZIP Code	Location No.
Phone No. ()	Fax No. ()	E-mail Address	
Signature (Required)		Date (Required)	RSM Name

Mail Plan to: Agent Primary Applicant
PLEASE NOTE: If neither box is checked, the Plan will be mailed directly to the primary applicant.
Mailing address: Agent, please mail this application to: **UNICARE, P.O. Box 5030, Bolingbrook, IL 60440-5030**

10. Statement of Accountability – To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:

Applicant does not read English Applicant does not speak English Applicant does not write English
 Other (explain): _____

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Application (Section 7)."

By **X** _____
Signature of Translator Today's Date (Required)

11. Conditional Receipt – To be completed by the agent and given to the applicant.

Received from _____ \$ _____ as a non-refundable application fee payable to UNICARE;
\$ _____ as a premium, payable to UNICARE.

Subject to the following:
IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE PREMIUM SUBMITTED WITH THIS APPLICATION IF THIS APPLICATION IS NOT APPROVED, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THIS APPLICATION IS APPROVED BY UNICARE.

Dated this _____ day of _____, 20 ____.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By **X** _____
Signature of Agent Agent I.D. Number

Notice of Information Practices

If you apply for or are covered by a UNICARE health care plan, UNICARE may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. For example, UNICARE may provide information to a hospital in order to verify benefits. Upon your request, UNICARE will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correction if you believe it to be inaccurate. UNICARE can choose to furnish the medical record information either directly to you or to a medical professional designated by you.

This is only a brief description of the plans. For complete details, including benefits, limitations and exclusions, please refer to the applicable plan.



UNICARE Life & Health Insurance Company
Sales Office
Houston, Texas

Insurance coverage is underwritten by UNICARE Life & Health Insurance Company.
® Registered Mark of WellPoint Health Networks Inc.

An application is required to be completed to apply for coverage and is subject to approval by UNICARE.

Rates effective 4/1/02
Benefits effective 2/1/03

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