



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

2-99 GROUP EMPLOYER APPLICATION

FOR UNICARE USE ONLY

GROUP NO.	UNDERWRITER NO.	EFFECTIVE DATE

1. EMPLOYER INFORMATION – The employer certifies the following information.

COMPANY NAME			
STREET ADDRESS (P.O. Box not acceptable)		CITY	STATE ZIP
BILLING ADDRESS		CITY	STATE ZIP
EMPLOYER IS <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other-Explain:			
COMPANY CONTACT PERSON		PHONE NO. ()	FAX NO. ()
DATE BUSINESS WAS ESTABLISHED (Mo/Yr)	TYPE OF BUSINESS (Be specific)	E-MAIL ADDRESS	SIC CODE
Has the company been insured by UniCare in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior UniCare coverage terminated: _____			
Has the employer filed for bankruptcy in the past seven years? <input type="checkbox"/> Yes <input type="checkbox"/> No			

For Consumer Choice and Pathways Plans only, PLEASE NOTE: You have the option to choose a Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, DOES NOT PROVIDE STATE-MANDATED HEALTH BENEFITS NORMALLY REQUIRED IN ACCIDENT AND SICKNESS INSURANCE POLICIES IN TEXAS. A standard health benefit plan may provide a more affordable health insurance policy for You although, at the same time, it may provide You with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose a standard health plan, please consult with your insurance agent to discover which state mandated health benefits are excluded in this policy.

2. MEDICAL COVERAGE SELECTION – MemberFlexSM

You may choose Performance Choice plans OR Consumer Choice Plans. HSA Compatible Plans are available in addition to Performance Choice Plans or Consumer Choice Plans or as standalone selections. Pathways Advantage is available with Performance Choice Plans, Consumer Choice Plans or HSA Compatible Plans. Pathways Suite can be offered as standalone products also.

Performance Choice <input type="checkbox"/> Single Plan <input type="checkbox"/> MemberFlex – Designate any or all plan options <input type="checkbox"/> Performance Choice 500 <input type="checkbox"/> Performance Choice 1000 <input type="checkbox"/> Performance Choice 2000 <input type="checkbox"/> Performance Choice 2500 <input type="checkbox"/> Performance Choice Saver 1000	Consumer Choice <input type="checkbox"/> Single Plan <input type="checkbox"/> MemberFlex – Designate any or all plan options <input type="checkbox"/> Consumer Choice 1000 <input type="checkbox"/> Consumer Choice 2500 <input type="checkbox"/> Consumer Choice HSA Compatible 2600 <input type="checkbox"/> Consumer Choice Saver 2000	HSA Compatible <input type="checkbox"/> Single Plan <input type="checkbox"/> MemberFlex – Designate any or all plan options <input type="checkbox"/> UniCare HSA Compatible A <input type="checkbox"/> UniCare HSA Compatible B <input type="checkbox"/> UniCare HSA Compatible C <input type="checkbox"/> UniCare HSA Compatible D	Pathways <input type="checkbox"/> Pathways Advantage <input type="checkbox"/> Pathways Suite Note: The Pathways Advantage plan can be offered as a standalone product or can be combined with other medical products. The Pathways Suite can only be offered as a standalone product.
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3. ADDITIONAL RIDERS

MATERNITY RIDER* (available with Consumer Choice Plans and High Deductible Health Plans or Pathways Plans for groups with 2-14 employees) *Not applicable for Performance Choice Plans, maternity benefits included within the plan.	<input type="checkbox"/> Add rider	<input type="checkbox"/> Decline rider	<input type="checkbox"/> N/A
IN-VITRO FERTILIZATION RIDER (NOT available with Consumer Choice Plans)	<input type="checkbox"/> Add rider	<input type="checkbox"/> Decline rider	<input type="checkbox"/> N/A
PLEASE NOTE: Maternity and In-Vitro Fertilization benefits MUST be offered consistently across all plan selections. (Example: If you choose to offer both Performance Choice Plans and HSA Compatible Health Plans, you MUST select the Maternity Rider with the HSA Compatible Plan.)			

4. DENTAL COVERAGE SELECTION – MemberFlexSM

<input type="checkbox"/> All plans OR	<input type="checkbox"/> Designate specific plan options (Check as many as apply)
High Options	<input type="checkbox"/> High Option FFS <input type="checkbox"/> GoldPremium
Medium Options	<input type="checkbox"/> Standard FFS <input type="checkbox"/> GoldPlus <input type="checkbox"/> GoldStandard
Low Options	<input type="checkbox"/> Basic FFS <input type="checkbox"/> SilverStandard
Voluntary Options	<input type="checkbox"/> UniCare VB <input type="checkbox"/> UniCare VS

5. MEDICAL RATING

Choose one rating methodology
<input type="checkbox"/> Individual Rating – each enrolling employee's rate depends on the employee's age, area, and family status.
<input type="checkbox"/> Composite Rating – rating factors for all enrolling employees are combined, and average amounts are charged for the four family categories of Employee Only, Employee and Spouse, Employee and Children, or Full Family.

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DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS

6. EMPLOYER CONTRIBUTION

<p>6A. EMPLOYER MEDICAL CONTRIBUTION OPTION</p> <p>Check one:</p> <p><input type="checkbox"/> Defined Contribution 100*</p> <p><input type="checkbox"/> Defined Contribution 80**</p> <p><input type="checkbox"/> Defined Contribution Select*** \$ _____</p> <p><input type="checkbox"/> Traditional Contribution**** _____ %</p> <p>* Employer contributes \$100 per employee per month. ** Employer contributes \$80 per employee per month. *** Employer selects contribution amount over \$100 per employee per month. **** Employer selects contribution amount of 50% or more per employee per month.</p>	<p>6B. PATHWAYS CONTRIBUTION SELECTION</p> <p>This option is only available when the Pathways Suite OR Pathways Advantage plan is selected with no other medical plans.</p> <p>Check one:</p> <p><input type="checkbox"/> Defined Contribution 30*</p> <p><input type="checkbox"/> Defined Contribution Select** \$ _____</p> <p><input type="checkbox"/> Traditional Contribution*** _____ %</p> <p>* Employer contributes \$30 per employee per month ** Employer selects contribution amount over \$30 per employee per month in \$5 increments. *** Employer selects contribution amount of 50% or more per employee per month.</p>	<p>6C. EMPLOYER DENTAL CONTRIBUTION OPTION</p> <p>Check one:</p> <p><input type="checkbox"/> Defined Contribution 15*</p> <p><input type="checkbox"/> Defined Contribution Select** \$ _____</p> <p><input type="checkbox"/> Traditional Contribution*** _____ %</p> <p><input type="checkbox"/> Voluntary Contribution**** _____ %</p> <p>* Employer contributes \$15 per employee, per month. ** Employer selects contribution amount over \$15 per employee, per month. *** Employer selects contribution amount of 50% or more per employee, per month. **** Employer selects contribution amount of 49% or less per employee, per month.</p>
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6D. SECTION 125 PREMIUM ONLY PLAN (P.O.P.) OPTION

Check if you would like to enroll in P.O.P. (You must fully read the P.O.P. application booklet, complete the application form, and submit the completed form and separate enrollment check along with this Employer Application.)

7. EMPLOYEE ELIGIBILITY

Total number of employees (including owners): _____ Number of **ineligible** employees: _____

Number of full-time (usually 30 hours per week) employees: _____ Number of **eligible** employees **declining** coverage: _____

Total number of eligible **enrolling** employees including COBRA/FMLA applicants: _____

Are all eligible employees subject to withholding as on a W-2 form? Yes No – Please explain: _____

Eligibility date is on the FIRST DAY of the month following the waiting period.

Waiting period for all future employees: 1 month 2 months 3 months

The following is to be completed by groups of 20 or more total employees and/or employer providing continuation of coverage in accordance with Title X of COBRA: Is your group subject to COBRA? Yes No If yes, please complete the COBRA/FMLA questionnaire.

The following question is to be completed by groups of 50 or more total employees and/or employer providing coverage in accordance with the Family and Medical Leave Act of 1993: Is your group subject to FMLA legislation? Yes No If yes, please complete the COBRA/FMLA questionnaire.

8. CURRENT CARRIER - Is this plan intended to replace any existing group coverage?

HEALTH: Yes No If yes, name of group carrier: _____ Proposed termination date: _____

DENTAL: Yes No If yes, name of group carrier: _____

LIFE: Yes No If yes, name of group carrier: _____ Anniversary date: _____

9. EFFECTIVE DATE - Actual effective date will be assigned by UniCare underwriting department if policy is issued.

Requested effective date: _____

10. LEAVE OF ABSENCE

A. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **personal** leave of absence:
 None 1 month 2 months 3 months 4 months

B. Number of months employees are eligible to continue group coverage while on an employer-approved temporary **medical** leave of absence (**maximum six months**):
 None 1 month 2 months 3 months 4 months 5 months 6 months

It is the Employer's responsibility to immediately notify UniCare at the beginning of any authorized leave of absence.

11. MEDICAL INFORMATION

To your knowledge:

1. Is any person to be covered unable to work due to injury or illness? Yes No

2. Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? Yes No

If yes to either question, provide names, dates, and degree of recovery: _____

12. WORKERS' COMPENSATION

Name of current Workers' Compensation carrier: _____ **Renewal date:** _____

Please list the name and job title of any person to be included as a subscriber under the UniCare coverage who is not an employee, for the purpose of Workers' Compensation law or similar legislation. Please note that under Texas law, partners and corporate officers, or members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances.

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

13. LIFE BENEFIT SELECTION – UniCare Life and AD&D Benefit Schedule.

- Option A** – \$15,000 flat amount for all employees
- Option B** – Any flat amount higher than \$15,000, maximum \$250,000 \$_____ (Must be in increments of \$5,000)
- Option C** – Graded benefits by Job Title – **Class I:** Officers, managers, supervisors, \$30,000 – **Class II:** All other employees, \$15,000
- Option D** – Graded benefits by Job Title – **Class I:** Officers, managers, supervisors, \$50,000 – **Class II:** All other employees, \$25,000
- Option E** – Graded benefits by Job Title – **Class I:** Officers, managers, supervisors, \$100,000 – **Class II:** All other employees, \$50,000
- Dependent Life Option:*** Yes No
 - \$5,000 \$10,000 **Must be completed if any of the above Life Benefit options are selected.*

13A. SUPPLEMENTAL LIFE BENEFIT SELECTION

Check if you are offering Supplemental Life Coverage to your employees.

The Supplemental Life premium may be 100% employee paid.

14. EMPLOYER CONTRIBUTION

LIFE CONTRIBUTION SELECTION

Check one:

Employee Life Premium _____%

Dependent Life Premium _____%

15. SIGNATURE/DISCLOSURE STATEMENT

Check the box that applies:

We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA, apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to binding arbitration only after the ERISA appeals procedure has been completed.

We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA, and therefore not subject to ERISA, apply to obtain the coverage indicated.

We represent that all information on this Application is true and complete, and that UniCare may rely on this Application in its decision to evaluate our group for eligibility and rating purposes. If not complete, UniCare reserves the right to reject the Application and notify us in writing. We understand and agree that coverage will be effective only if we have paid our first month's premium and have met eligibility criteria. We understand that we will be informed of acceptance and effective date in writing if this Application is issued, that we should keep prior coverage in force until so notified and that no agent or broker has the right to accept Application or bind coverage. This Application becomes a part of our contract with UniCare. **We verify that these answers are true and that coverage may be re-evaluated for eligibility and rating purposes should it be determined at a future date that there are misstatements in these Application forms. We have provided the individual or the person through whom the individual was eligible to be covered as a dependent prior to declining coverage with an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose at the time of the individual's later decision to elect coverage, an exclusion from coverage until the next open enrollment period as well as a pre-existing condition exclusion for twelve (12) months from the effective date of coverage, and received signed acknowledgement of the notice.**

The Consumer Choice Plan(s) and Pathways Plan(s) do not provide some state-mandated health benefits. For Groups with no more than 50 eligible employees, state-mandated benefits not included are: 1) Serious Mental Illness; 2) Oral Contraceptives, Prescription Contraceptive Drugs and Devices and Related Services (unless the plan includes maternity benefits); 3) Chemical Dependency; 4) In-Vitro Fertilization; and 5) Speech and Hearing. Purchase of this Plan may limit your future coverage options in the event your health changes and needed benefits are not available under this Plan.

The Consumer Choice Plan(s) and Pathways Plan(s) do not provide some state-mandated health benefits. For Groups with more than 50 eligible employees state-mandated benefits not included are: 1) Telemedicine/Telehealth; 2) Chemical Dependency; 3) In-Vitro Fertilization; 4) Speech and Hearing. Purchase of this Plan may limit your future coverage options in the event your health changes and needed benefits are not available under this Plan.

Composite rates may be recalculated if a change in membership would otherwise result in a premium change for the group of more than 10%.

ARBITRATION AGREEMENT: We understand that any dispute between us and UniCare may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing such arbitration. The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the policyholder or, if applicable, beneficiary resides. By signing this application, we are not agreeing to binding arbitration.

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

By **X** _____ Title _____
(Signature of Company Officer / Owner)

16. CONDITIONAL RECEIPT – Agent, please photocopy and give to your client.

This will acknowledge receipt of \$ _____ from _____

as a deposit against the insurance premiums that would become payable if UniCare Life & Health Insurance Company accepts this Application for group coverage. This check will be held in trust by UniCare pending acceptance or rejection of the Application. I have fully explained to the employer that in no event will benefits be payable for any loss incurred before the effective date assigned by UniCare Life & Health Insurance Company and that the company should retain any other coverage until then.

17. AGENT'S CERTIFICATION

1. I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk.			
2. I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notification from UniCare the coverage being applied for by this application is issued.			
1. NAME OF WRITING AGENT (Print or Type)	%	AGENT TAX I.D. NO.	(CHECK ONE) <input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
AGENT ADDRESS		PHONE NO. ()	FAX NO. ()
CITY / STATE / ZIP			
SIGNATURE OF AGENT X			DATE
2. NAME OF <input type="checkbox"/> SUB-AGENT <input type="checkbox"/> SECOND WRITING AGENT (Print or Type)	%	AGENT TAX I.D. NO.	(CHECK ONE) <input type="checkbox"/> E = EIN <input type="checkbox"/> S = SS#
AGENT ADDRESS		PHONE NO. ()	FAX NO. ()
CITY / STATE / ZIP			
SIGNATURE OF SECOND AGENT X			DATE
3. NAME OF GENERAL AGENT		AGENT TAX I.D. NUMBER	

Send Administration Kit to: <input type="checkbox"/> Agent <input type="checkbox"/> Group
