



ILLINOIS 2-99 GROUP EMPLOYER APPLICATION

The various products listed in the application may be offered by any of the following companies: UniCare Health Insurance Company of the Midwest, UniCare Health Plans of the Midwest, Inc. or UniCare Life & Health Insurance Company. Please refer to the Employer Policy for the name of the offering company for the products you have selected.

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GROUP NO.	UNDERWRITER NO.	EFFECTIVE DATE
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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			

2. MEDICAL COVERAGE SELECTION - MemberFlexSM

Premier Flex Plus/ Premier Flex Options <input type="checkbox"/> Premier Flex Plus 500/90 <input type="checkbox"/> Premier Flex Plus 500 <input type="checkbox"/> Premier Flex Plus 1000 <input type="checkbox"/> Premier Flex Plus 2000 <input type="checkbox"/> Premier Flex 2500 <input type="checkbox"/> Premier Flex Saver 1000	Flex Advantage Options <input type="checkbox"/> Flex Advantage 1000 <input type="checkbox"/> Flex Advantage 2000 <input type="checkbox"/> Flex Advantage 2500 <input type="checkbox"/> Flex Advantage Saver 2000	HSA Compatible 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 Options <input type="checkbox"/> Pathways Advantage <input type="checkbox"/> Pathways Plus <input type="checkbox"/> Pathways Essentials
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3. ADDITIONAL RIDERS

Maternity Rider* <input type="checkbox"/> Add rider <input type="checkbox"/> Decline rider <input type="checkbox"/> N/A Available with Flex Advantage plans, HSA Compatible plans and Pathways plans for groups with 2-14 employees. Maternity benefits are automatically included for all groups of 15 or more employees. *Not applicable for Premier Flex Plus/Premier Flex plans, maternity benefits included within the plan.
MENTAL HEALTH RIDER <input type="checkbox"/> Add rider <input type="checkbox"/> Decline rider <input type="checkbox"/> N/A
PLEASE NOTE: Maternity benefits MUST be offered consistently across all plan selections. Groups with 2-14 employees that choose to offer Premier Flex Plus/Premier Flex plans, MUST select the maternity rider for any other plan options.

4. DENTAL COVERAGE SELECTION - MemberFlexSM

<input type="checkbox"/> All plans OR High Options Medium Options Low Options	<input type="checkbox"/> Designate specific plan options Check as many as apply. <input type="checkbox"/> High Option FFS <input type="checkbox"/> High Option PPO <input type="checkbox"/> GoldPremium <input type="checkbox"/> Standard FFS <input type="checkbox"/> Standard PPO <input type="checkbox"/> GoldPlus <input type="checkbox"/> GoldStandard <input type="checkbox"/> Basic FFS <input type="checkbox"/> Basic PPO <input type="checkbox"/> SilverStandard	Voluntary Selection Voluntary Dental is an alternative election and is not available in conjunction with the other plans. <input type="checkbox"/> UniCare VB <input type="checkbox"/> UniCare VS
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5. MEDICAL RATING

Employers with 15 or more enrolling employees - 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.
PLEASE NOTE: Life rates for groups of 11 or more enrolling employees are automatically composite rated.

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DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS
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6. EMPLOYER CONTRIBUTION SELECTION

<p>6A. EMPLOYER MEDICAL CONTRIBUTION SELECTION</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 in \$5 increments. **** Employer selects contribution amount of 50% or more per employee per month.</p>	<p>6B. PATHWAYS CONTRIBUTION SELECTION</p> <p><i>This option is only available when the Pathways Suite OR Pathways Advantage plan is selected with no other medical plans.</i></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. DENTAL CONTRIBUTION SELECTION</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 in \$5 increments. *** 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.

Administrative services provided by Ceridian Benefit Services, Inc., an independent company that is not owned by or affiliated with any of the UniCare companies, their affiliates, subsidiaries or parent company.

7. EMPLOYEE ELIGIBILITY

Number of full-time usually 30 hours per week employees including owners: _____

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

Are all eligible employees including owners 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 future employees: None 1 month 2 months 3 months 6 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: _____

DISABILITY: 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 Illinois 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?
 Yes No
 Yes 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. DISABILITY BENEFIT SELECTION

14A. SHORT TERM DISABILITY SELECTION				14B. LONG TERM DISABILITY SELECTION			
Check One:				Check One:			
	8th day- 13 wks	8th day- 26 wks	15th day- 26 wks		Gold 60%	Silver 60%	Bronze 50%
66.67%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	90	<input type="checkbox"/>	<input type="checkbox"/>	
\$200.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	180	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OR

14C. SECUREPACK:

BASIC
 ESSENTIAL
 ENHANCED
 DELUXE
 PREMIUM

15. EMPLOYER CONTRIBUTION SELECTION

LIFE AND DISABILITY CONTRIBUTION SELECTION

Check one:

Employee Life Premium _____%

Dependent Life Premium _____%

Employee LTD Premium _____%

Employee STD Premium _____%

SecurePack Premium _____%

16. SIGNATURE AND CONDITIONAL RECEIPT

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, 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 rescinded or 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 the lesser of twelve (12) months from the effective date or 18 months from the date of the application, and received signed acknowledgement of the notice.**

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

NOTICE: All doctors, hospitals and providers listed in the Directory of Providers are independent contractors. They are not agents or employees of UniCare. When you or a covered member of your family select a Primary Care Physician or seek care from a network provider, either directly or by referral from another provider, you are seeking care from that provider, not from UniCare. UniCare does not control, nor does it have a right to control, any aspect of a provider's medical judgement. UniCare's decisions about whether any medical service or supply is covered under your health plan are insurance benefit decisions only and are not the provision of medical care. UniCare is not responsible for, does not provide, and does not hold itself out as a provider of, medical care. Only the doctors who treat you and your family can provide medical care, and only those doctors are responsible for any negligence in providing that medical care. If a service or supply is not eligible for benefits, you and your provider are free to proceed with that service or supply knowing that benefits are not available under your health plan.

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 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 and that the company should retain any other coverage until then.

17. AGENT'S CERTIFICATION

- 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.
- 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 AGENT X			DATE
3. NAME OF GENERAL AGENT		AGENT NO. TIN	

Send Administration Kit to: Agent Group