Application & Enrollment Form

☐ *New Group Enrollment* ☐ *Addition of Dependent* ☐ *Late Enrollment*
☐ *Change of CMG/IPA Physician* ☐ *New Hire* ☐☐/☐☐/☐☐ *Requested Effective Date*
Check Desired Plan As Offered by Employer:
☐ *Full Network* ☐ *ChampionHEALTH* ☐ *P.O.S.* *Plan Selected*_____

Universal Care®
Healthcare you can feel good about.
1600 East Hill Street • Signal Hill, CA 90755
(800) 635-6668 ext. 4848
www.universalcare.com

Applicant Information. Applicant must complete this section.

Last Name	First Name	M.I.	Home Phone No.
			( )

Home Address *Must be complete. P.O. Box not acceptable*	☐ Single ☐ Married	Date of Marriage Month / Day / Year	Work Phone No.
			( )

City	State	Zip Code	E-Mail Address

Employer	Group # (if assigned)	Occupation	Date of Hire Month / Day / Year

Applicant/Family Information:
List *yourself* and all eligible family members to be enrolled. If a listed member's last name is different from yours, please explain below. *Height and weight must be stated accurately.*

Provider Selection:
Please select a Primary Care Physician for each family member to assure prompt processing of this application.

Last Name	First Name	M.I.	Height/Weight	Date of Birth	Social Security Number	Name of Primary Care Physician	PCP# / CMG#	Current Doctor? Y N
☐M ☐F *Applicant*				Month / Day / Year				☐ ☐
☐M ☐F *Spouse*				Month / Day / Year				☐ ☐
☐M ☐F *Dependent*				Month / Day / Year				☐ ☐
☐M ☐F *Dependent*				Month / Day / Year				☐ ☐
☐M ☐F *Dependent*				Month / Day / Year				☐ ☐
☐M ☐F *Dependent*				Month / Day / Year				☐ ☐

Different last name explanation:

If Available, I would prefer to receive materials in the following language. _____.
The following information is voluntary and will help us to better serve your needs. Please check the ethnicity with which you most closely identify.
☐ Alaskan/Native American ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other_____

Other Health Insurance

Please fill out this section if you and any of your eligible family members are currently covered by other medical insurance or had previous health insurance.

Name of Member(s)	Previous Insurer	Policy Number	Policy effective Date Month / Day / Year	Employer's Name

Name of Member(s)	Current Insurer	Policy Number	Policy effective Date Month / Day / Year	Employer's Name
	Name *Address* *City* *State* *Zip*			

Are you or any member(s) of your family eligible for Medicare? ☐ Yes ☐ No

Name	*Name*	*Name*

Coverage Declination

To be completed if any Universal Care coverage is declined or refused by an eligible employee and/or their eligible family members.

1. Health Plan Coverage (check if declined)
I decline coverage for:
☐ Myself ☐ Children Only
☐ Spouse Only ☐ Spouse and Children ☐ Medicare ☐ Other (explain):_____

2. Reason for Declining Health Plan Coverage (check one)
☐ Covered by Spouse's Group Coverage
☐ Spouse covered by Employer's Group Medical Coverage
☐ Covered by CHAMPUS or CHAMPVA
☐ Enrolled in another Group Plan

Carrier Name

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to define coverage. **I know that if I later decide to elect coverage, and I was not covered under another employer health benefit plan during the initial enrollment period, I and/or my dependents will be considered a late Enrollee and will be subject to a 12 month waiting period from the date I later decide to elect coverage.** I may also be subject to a six-month pre-existing condition exclusion. My decision not to apply for coverage now could leave me without coverage later.

Employee Signature *(Sign only if declining coverage for yourself or eligible family members.)*	Date Month / Day / Year

Health Questionnaire

Has any person listed in this application ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment or been hospitalized for any of the following conditions? All questions must be checked *Yes* or *No*, circle the conditions applicable and provide the information requested below.

	YES	NO
1. Brain/nervous system - dizziness, headaches, seizure disorder, loss of consciousness, epilepsy, paralysis, any neuromuscular disease such as: muscular dystrophy, multiple sclerosis, stroke, ALS, cerebral palsy, polio, mental retardation, history of malignant or nonmalignant tumor?	☐	☐
2. Cardiovascular system - heart or valve problems, coronary artery disease, heart attack, congestive heart failure, heart murmur, pericarditis, mitral valve prolapse, mitral regurgitation, rheumatic fever, palpitations, high blood pressure, shortness of breath, chest pain, previous open heart surgery, congenital heart disease, palpitations, fainting spells?	☐	☐
3. Circulatory system - varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder, anemia, enlarged lymph nodes, white blood cell problems; red blood cell problems, platelet disorder?	☐	☐
4. Respiratory tract - asthma, reactive airway disease, bronchitis, hay fever, allergies, sinusitis, lung/chest problems of any kind, emphysema, tuberculosis, spitting or coughing up blood, shortness of breath, pneumonia, cystic fibrosis, pulmonary fibrosis, chronic obstructive pulmonary disease, lung tumor benign or malignant, fungal disease of the lung, sarcoidosis?	☐	☐
5. Digestive system - mouth, tongue, esophagus or stomach problems, ulcer, gall bladder disorder, liver disease, cirrhosis, jaundice, ascites, hepatitis, pancreatis, colon, intestinal or rectal problems, colitis, chronic diarrhea, hemorrhoids, hernia, weight or eating problems, Hirschsprungs Disease, Crohns, ulcerative colitis, blood in stool, vomiting of blood?	☐	☐
6. Urinary tract - renal colic, gravel or stone, urethra, bladder or kidney problems, infections, stricture, pyelonephritis, kidney tumor, blood in urine, tumor of the ureter or urethra or bladder, previous trauma to the bladder or genitals?	☐	☐
7. Male reproductive system - prostate problems, infertility, impotency, infections, herpes, syphilis, gonorrhea, or other venereal disease, infection or inflammation of the testicle, born with only one or no testicles, or history of undescended testicles, cancer of the testicles, cancer of the prostrate, cancer of the penis?	☐	☐
8. Female reproductive system - breast problems including implants, adhesions, abnormal bleeding, endometriosis, fibroid tumors, abnormal Pap tests, problems of the ovaries, uterus and associated female organs, infertility, infections, genital warts, herpes, syphilis or other venereal disease, excessive bleeding during menses, abnormal menses, excessive hair on face or abdomen, Turner's syndrome, Stein-Leventhal syndrome?	☐	☐
9. Skin conditions - skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, Erythema Nodosum, caposi sarcoma, hemangioma, port wine birth marks?	☐	☐
10. Metabolic system - diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, immune system disorders, lupus, erthematosis, Raynaud's disease, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT or Pentamidine therapy? (CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING COVERAGE)	☐	☐
11. Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing - such as: any infections, crossed eyes, cataracts, detached retina, polyps, deviated nasal septum, nose bleeds, hoarseness, ringing in the ears, growths in the ears, nose, mouth or eyes, excessive smoking, neoplasm of the eye, previous trauma to the eyes, ears, nose or throat?	☐	☐
12. History of cancer, tumor, cysts in any location or organ of the body?	☐	☐
13. Alcoholism, drug dependency or substance abuse?	☐	☐
14. Presently a member of a support group? How long?	☐	☐
15. Congenital anomoly of any organ, birth defects - Down's syndrome, Cerebral Palsy, cleft lip or palate, clubfoot, development delay, mental retardation, or other neurological or physical abnormalities?	☐	☐
16. Is any applying family member expecting to be a mother or father (expecting a child)? Expected delivery or adoption date: ________________	☐	☐
17. Musculo-Skeletal system - neck, spine/back sprain, pain, injury, or problems; sciatica, curvature of the spine, scoliosis; any pain, injuries, or problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis, temporal/mandibular joint syndrome (TMJ), Lyme disease, fractures/residual hardware, dislocations, bunions, hammertoe, carpal tunnel syndrome, physically handicapped, polio, any amputation, plantar warts, chronic heel pain, chronic muscle pain or cramping?	☐	☐

Please explain and provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in the preceding boxes. Include name of family member, nature of illness, dates and duration of treatment. In addition, please give details below of last doctor visit and/or physical examination for all family members listed regardless of the date or reason.

Attach additional sheets if necessary.

Condition No.	Family Member Name (Name used on doctor's record)	Name of hospital, full name of every physician or clinic (include zip code)	Name of condition(s) or illness(es) treated	Indicate treatment rendered such as check-ups, x-rays, lab and surgical procedures, etc.
	Name ______ *Medical Record Number (if known)* ______ *Date Began: Mo.* ______ *Yr.* ______ *Still under treatment:* ☐ *Yes* ☐ *No* *Date Ended:* / /	*Name* ______ *Address* ______ *City* *State* *Zip* *Phone* ( )		______ *Medication Taken:* ______ *Date Prescribed:* ______ *Dosage:*
	Name ______ *Medical Record Number (if known)* ______ *Date Began: Mo.* ______ *Yr.* ______ *Still under treatment:* ☐ *Yes* ☐ *No* *Date Ended:* / /	*Name* ______ *Address* ______ *City* *State* *Zip* *Phone* ( )		______ *Medication Taken:* ______ *Date Prescribed:* ______ *Dosage:*
	Name ______ *Medical Record Number (if known)* ______ *Date Began: Mo.* ______ *Yr.* ______ *Still under treatment:* ☐ *Yes* ☐ *No* *Date Ended:* / /	*Name* ______ *Address* ______ *City* *State* *Zip* *Phone* ( )		______ *Medication Taken:* ______ *Date Prescribed:* ______ *Dosage:*

Health Questionnaire continued

	YES	NO	Please answer each question. If yes, please provide details in the space provided.
• Have any applying persons ever smoked cigarettes, cigars or pipes, or used chewing tobacco products. If yes, how many per 24 hours and for what period of time?	☐	☐	Person: Packs per day: How many years: When did you/they stop:
• Do any applying persons drink alcoholic beverages?	☐	☐	Person: Drinks per week: Type:
• Have any applying persons ever had any application for health or life insurance declined, postponed or restricted in any way?	☐	☐	Person: Please explain:
• Have any applying persons ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	☐	☐	Person: Please explain:
• Has any applying person had other health coverage (insurance) within the last 6 months? Type of coverage: Single/Family Group HMO Disability Medicare Short Term or Interim Other	☐	☐	Person: Please explain:
• Have any applying persons ever received any counseling or treatment for symptoms of depression, manic depression, anxiety, panic attacks, nervousness, mental or emotional disorders, schizophrenia, behavior problems, hyperactivity, attention deficit disorder, eating disorders, bulimia, anorexia, alcohol or substance abuse, or for any other reason?	☐	☐	Person: Please explain:
• Have any applying persons ever been a patient in a hospital, clinic, sanatorium, or other medical facility? For how long and how many years ago?	☐	☐	Person: Please explain:
• Have any applying persons ever had any surgery including cosmetic/reconstructive surgery?	☐	☐	Person: Please explain:
• Have any applying persons ever had abnormal laboratory results, blood work, X-rays, EKG's, EMG's, nerve conduction or blood flow studies, CT Scans, MRIs or PET Scans or angiograms?	☐	☐	Person: Please explain:
• Do any applying persons have a prosthesis, implant, or retained hardware?	☐	☐	Person: Please explain:
• Have any applying persons been advised to undergo further testing, treatment or surgery which has not yet been performed by a physician, dentist, or other provider?	☐	☐	Person: Please explain:
• Have any applying persons had any pain or difficulty breathing, chewing, swallowing, jaw problems either medical or dental?	☐	☐	Person: Please explain:
• Has anyone had treatment in the last 10 years, contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing health care services?	☐	☐	Person: Please explain:
• Do any applying persons presently have any condition or illness not mentioned elsewhere on this application or complications or residuals remaining following any treatment?	☐	☐	Person: Please explain:

I, the undersigned, represent that: All information on this application is true and complete to the best of my knowledge, and that no material information has been withheld or omitted concerning the past and present state of the applicant's or any family member's health.

I, the undersigned, understand that: I herewith give my consent to all doctors, hospital and providers of health services to furnish any and all records pertaining to my family's or my own medical history. Universal Care may require prior medical records and that the applicant agrees to sign a Medical Records Release form.

Universal Care will rely upon the application information for rejecting or contracting with the applicant, and the discovery of additional material facts, known by the applicant but not disclosed herein, may result in the rescission or modification of any contract entered into.

I hereby authorize my employer or association to deduct my paycheck any required contribution for group benefits for which I am eligible, and I shall abide by the provisions of coverage in the service agreement under which I am enrolled.

It is my responsibility to report any change in eligibility of my dependents.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNIVERSAL CARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

By my signature below, I acknowledge that I have received a copy of Universal Care's Notice of Privacy Policy.

Subscriber Signature (Applicant)	Date (Month / Day / Year)

For Office Use Only

Member #	Plan Code	Broker #	Effective Date (Month / Day / Year)	Reviewed By	Date (Month / Day / Year)

Group #	Agent #	Dental Center Code	Medical Center Code	Approved By	Date (Month / Day / Year)

Application Checklist:

- ✔ **List all eligible dependents you wish to enroll.**
- ✔ **List the name of the Primary Care Physician and the physician number for yourself and each family member.**
- ✔ **Complete the "Other Health Insurance" section if you or any family member has additional coverage.**
- ✔ **Answer all health questions. Provide details for all "Yes" answers.**
- ✔ **Initial and date any edits/corrections.**
- ✔ **Attach additional sheets if necessary.**
- ✔ **Completed, signed and dated by employee.**

Questions? Please contact us.

Member Services Department	**800-635-6668**
Sales Department	**800-380-2522**
Visit our website	**www.universalcare.com**

Universal Care®
Healthcare you can feel good about.

Corporate Offices:
1600 East Hill Street
Signal Hill, CA 90755
www.universalcare.com