Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: Universal Care

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...

universalcare®
HEALTHCARE YOU CAN FEEL GOOD ABOUT

CHOOSING THE PLAN
THAT'S RIGHT FOR YOU

CHOOSING YOUR BENEFIT PLAN

We're pleased to offer two benefit plan options for individuals and their families – Personal Plan 15 and Personal Plan 30. Both offer the same excellent benefits, but you have the freedom to choose the level of copayment that best fits your budget. You'll find a Summary of Plan Benefits on the following pages and rates in the enrollment packet.

PRESCRIPTION DRUG BENEFIT

Universal Care covers prescription drugs on a formulary basis (including birth control pills and prescriptions for confirmed diagnosis of Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major depressive disorders, Panic disorder, Obsessive-Compulsive disorder, Anorexia Nervosa, Bulimia Nervosa, Autism and Serious Emotional Disturbances in children) prescribed by a Universal Care physician if and only if they are dispensed at a contracted pharmacy.

PRIMARY CARE PHYSICIAN

All of your medical care will be coordinated and managed through the Universal Care Primary Care Physician of your choice. Each covered family member can select his or her own Primary Care Physician from a Contracted Medical Group. These doctors become familiar with your specific medical needs, thereby offering you quality care and appropriate referrals to specialists whenever needed.

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If you have any questions about which plan is best for you and your family, please call your broker or call Universal Care at **800-380-2522**. We'll be happy to assist you.

ENROLLING IN UNIVERSAL CARE IS EASY

1) Once you've selected the benefit plan for you and your family members, complete the Application and Enrollment Form.
2) On the Application and Enrollment Form, you are asked to select a Primary Care Physician for each applicant from a Contracted Medical Group or the Champion Network. To make your selection, just follow the simple directions in the Provider Directory which is enclosed with this brochure.
3) You may also want to take a moment to review the Dental Plan Option information located in the enrollment packet. If you choose to enroll, just check the appropriate box on the Application and Enrollment Form, and then fill out the Dental Plan Enrollment Form.
4) Use the Rate Schedules in the enrollment packet to calculate your first month's premium. Please note there are premium differences depending on Network selection. (If you choose the Dental Option, make sure you add your dental premium amount to your first month's medical premium.)
5) Write a check for the total monthly premium amount, payable to Universal Care, and enclose it with your Application and Enrollment Forms in the envelope provided.
6) If you elect the convenience of pre-authorized payment from your checking account, fill out the enclosed Electronic/Automatic Payment Form, and return it with your application.

   In the event you have any questions, feel free to call us at **800-380-2522**.

PERSONAL PLAN
APPLICATION AND ENROLLMENT FORM

Benefit Plan (check appropriate choice)

☐ **Personal Plan 15** ☐ **Personal Plan 30**

☐ **Dental Plan**

Check Desired Network:

☐ **Universal Care Network**

☐ *Champion*HEALTH **Network**

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HEALTHCARE YOU CAN FEEL GOOD ABOUT

1600 East Hill Street
Signal Hill, CA 90755-3682
800-380-2522
www.universalcare.com

Requested Effective Date

Month	Date	Year

☐ *New Enrollment* ☐ *Addition of Dependent* ☐ *Change of Primary Care Physician*

Actual effective date will be assigned by the Underwriting Department of Universal Care upon acceptance. Please allow 30 days for processing.

Individual / Family

The Applicant Certifies the following Information:

(Indicate the younger spouse as the applicant)

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

Home Address *Must be complete – P.O. Box not acceptable*	E-Mail Address

City	County	State	Zip Code	Work Phone No.
				( )

Employer	Occupation	Date of Hire (Month / Day / Year)

Applicant's Employer Address	City	State	Zip Code

Spouse's Occupation	Spouse's Employer	Work Phone No.
		( )

Spouse's Employer Address	City	State	Zip Code

Applicant / Family Information

List *yourself* and all eligible family members to be enrolled. If a listed family member's 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 (Month / Day / Year)	Social Security #	Name of Primary Care Physician	Physician No.	Check if current patient
Applicant ☐ M ☐ F									
Applicant ☐ M ☐ F									
Applicant ☐ M ☐ F									
Applicant ☐ M ☐ F									
Applicant ☐ M ☐ F									
Applicant ☐ M ☐ F									

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 ☐ African American ☐ Asian/Pacific Islander
☐ Caucasian ☐ Hispanic ☐ Other

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.

	Condition	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:*

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:*

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:*

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:

Please provide information regarding the last doctor visit and/or physical examinations for ALL persons applying.

Name of Family Member	Date of Visit	Reason For Visit and Results	Name and Address of Attending Physician/Clinic

List all medications taken currently or within the last year by any persons listed on this application.

Name of Family Member	Name and Address of Attending Physician

List Medication(s)	Date Prescribed	Date Discontinued	List Medication(s)	Date Prescribed	Date Discontinued

Please attach additional sheets of paper to provide further information for the application, if necessary. List the page number. section name and condition you are explaining. Also, please identify the applicable family member.

Attach additional sheets if necessary.

ANY MISREPRESENTATIONS RELATED TO PRE-EXISTING IMPAIRMENT OR DISEASE MAY VOID YOUR COVERAGE. INCOMPLETE APPLICATIONS WILL BE RETURNED WHICH MAY DELAY PROCESSING AND ELIGIBILITY.

Conditions of Membership and Signature

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 give my consent to all doctors, hospitals and providers of health services to furnish any and all records pertaining to my family's or my own medical history, including dates of treatment, nature of accident or sickness and record of surgery, patient records of members and any information concerning AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex), which Universal Care requires, to a representative of Universal Care for review and keeping. A photocopy of this request is as valid as the original.

Universal Care will rely upon the accuracy and completeness of the application information, for contracting with or for rejecting 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. It is my responsibility to report any changes in my eligibility or that 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.

If the sole Applicant under this application is under 18 years of age, Applicant's parent or legal guardian must sign below as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for payment of fees. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this application.

I understand and agree that by enrolling or accepting services under this Health Plan, I and any enrolled dependents are obligated to understand and abide by all terms, conditions and provisions of the Universal Care Subscriber Agreement.

I have read and understand the terms of this Application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct.

Please see the Combined Evidence of Coverage and Disclosure Form, as well as the Individual Subscriber Agreement for additional information on benefit exclusions and limitations.

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

Attached is my personal check or money order in an amount equal to one month's dues as my deposit. It will be refunded if my application is not approved. If I am accepted, this application will become part of the agreement between Universal Care and myself and enrolled dependents. Coverage is effective upon approval by Universal Care and Notification to Applicant.

Signature of Applicant / Parent or Legal Guardian *(Required)*	Today's Date *(Required)*

Signature of Spouse / Parent or Legal Guardian *(Required)*	Today's Date *(Required)*

Signature of Applicant's Dependent Age 18 or over *(Required)*	Today's Date *(Required)*

Signature of Applicant's Dependent Age 18 or over *(Required)*	Today's Date *(Required)*

• IMPORTANT – ALL SIGNATURES MUST INCLUDE TODAY'S DATE •

Agent's Certification

I hereby certify that I am not aware of any information not disclosed in this application or enrollment form by my client which may have a bearing on this risk.
I hereby certify that I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by the applicant is accepted.

Writing Agent's Name	Agent #	Telephone Number

Agent's Address	Tax I.D .Number

Agent's Signature	Date (Month / Day / Year)

For Company Use Only

Reviewed By	Date	Effective Date	Subscriber#	SA#

Approved By	Date		UCR#	GA#

PERSONAL PLAN

AUTOMATIC PAYMENT PROGRAM

Universal Care *is proud to present our new Automatic Payment Program. This service allows you to pay your monthly Health Plan dues without having to write a check. You simply authorize an automatic withdrawl from your checking account each month.*

Smart	No check writing charges. Your monthly payment is always on time.
Convenient	No more hassle of writing a check every month.
Easy	To start this service, please complete the following: 1. Complete and sign the Electronic/Automatic Payment Authorization Form. 2. Return the completed Electronic/Automatic Payment Authorization Form with a voided check to ensure accurate account information. 3. Mail to: ***Universal Care*** *Accounting Department* *1600 East Hill Street* *Signal Hill, CA 90755-3682* 4. Please continue to send in your monthly payment until you are notified of the start date of the Automatic Payment Program. *(Please allow 30 days for processing)*

If you have any questions, please call us at ***800-380-2522***

ELECTRONIC/AUTOMATIC PAYMENT FORM

Subscribers Name _____

Universal Care Member I.D. Number (if applicable) _____

Address _____

City _____ State _____ Zip _____

Daytime Telephone _____

Financial Institution _____ Branch _____

Bank Account Holder Name(s) _____

Checking Account Number _____

Bank Routing Number _____

I (we) hereby authorize Universal Care and the designated financial institution to initiate transfers from my (our) checking account monthly to pay my (our) health plan dues as indicated by Universal Care.

I (we) understand it is my (our) responsibility to notify Universal Care of any changes to my bank account. Either Universal Care or I (we) can terminate the Electronic/Automatic Payment Program process with written notification and in such time and manner as to afford Universal Care and my (our) Financial Institution a reasonable opportunity to act on it.

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Bank Account Holder's Signature _____ Date _____