

PERSONAL PLAN

APPLICATION AND ENROLLMENT FORM

Benefit Plan (check appropriate choice)

- Personal Plan 10 Personal Plan 20
 Dental Plan Other

Check Desired Network:

- Universal Care Network
 ChampionHEALTH Network



Universal Care®
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 CMG/IPA 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 <small>Must be complete – P.O. Box not acceptable</small>				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:

For Universal Care Network, please select a Contracting Medical Group (CMG) or a physician from an Independent Practice Association (IPA) for each family member.

For ChampionHEALTH Network, please select a location for each family member.

Last Name	First Name	M.I.	Height/Weight	Date of Birth	Social Security #	CMG/IPA Physician / Champion Location	Physician No.	Check if current patient
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				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 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.

	YES	NO		YES	NO
1. Brain/nervous system - dizziness, headaches, seizure disorder, loss of consciousness, epilepsy, paralysis, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, polio, mental retardation, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	10. Metabolic system - diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc. and immune system disorders, such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT or Pentamidine therapy, etc?	<input type="checkbox"/>	<input type="checkbox"/>
2. Cardiovascular system - heart or valve problems, coronary artery disease, heart attack, heart murmur, pericarditis, mitral valve prolapse, mitral regurgitation, rheumatic fever, palpitations, high blood pressure, shortness of breath, chest pain, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	(CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING COVERAGE)		
3. Circulatory system - varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder, anemia, or enlarged lymph nodes, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	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, excessive smoking, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc?	<input type="checkbox"/>	<input type="checkbox"/>	12. Cancer, tumor, cysts, leukemia, Hodgkins, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc?	<input type="checkbox"/>	<input type="checkbox"/>	13. Alcoholism, drug dependency or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
6. Urinary tract - renal colic, gravel or stone, urethra, bladder or kidney problems, infections, stricture, pyelonephritis, etc?	<input type="checkbox"/>	<input type="checkbox"/>	14. Presently a member of a support group? How long?	<input type="checkbox"/>	<input type="checkbox"/>
7. Male reproductive system - prostate problems, infertility, impotency, infections, herpes, syphilis, gonorrhea, or other venereal disease, etc?	<input type="checkbox"/>	<input type="checkbox"/>	15. Congenital abnormalities, birth defects - Down's Syndrome, Cerebral Palsy, cleft lip or palate, clubfoot, development delay, mental retardation, or other neurological or physical abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc?	<input type="checkbox"/>	<input type="checkbox"/>	16. Is any applying family member expecting to be a mother or father (expecting a child)? Expected delivery or adoption date: _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Skin conditions - skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, etc?	<input type="checkbox"/>	<input type="checkbox"/>	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, amputation, etc.?	<input type="checkbox"/>	<input type="checkbox"/>

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.
<input type="checkbox"/>	Name Medical Record Number (if known) Date Began: Mo. _____ Yr. _____ Still under treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: / /	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: Dosage:
<input type="checkbox"/>	Name Medical Record Number (if known) Date Began: Mo. _____ Yr. _____ Still under treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: / /	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: Dosage:
<input type="checkbox"/>	Name Medical Record Number (if known) Date Began: Mo. _____ Yr. _____ Still under treatment: <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Packs per day: _____ How many years: _____ When did you/they stop: _____
• Do any applying persons drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Have any applying persons ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Did any applying person have other health coverage (insurance) within the last 6 months? Type of coverage: <input type="checkbox"/> Single/Family <input type="checkbox"/> Group <input type="checkbox"/> HMO <input type="checkbox"/> Disability <input type="checkbox"/> Medicare <input type="checkbox"/> Short Term or Interim <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Have any applying persons ever been a patient in a hospital, clinic, sanatorium, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Have any applying persons ever had any surgery including cosmetic/reconstructive surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Have any applying persons ever had abnormal laboratory results, blood work, X-rays, Ekg., nerve conduction or blood flow studies?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Do any applying persons have a prosthesis, implant, or retained hardware?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Have any applying persons had any pain or difficulty breathing, chewing, swallowing, jaw problems either medical or dental, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	Person: _____ Please explain: _____
• Has anyone had treatment in the last 10 years, contracted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing health care services?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	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.

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 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		()
Agent's Signature		Tax I.D. Number
<i>Marsha Andrews</i>		
		Date
		Month Day Year

 For Company Use Only

Reviewed By	Date	Effective Date	Subscriber#	SA#
Approved By	Date		UCR#	GA#