

# UniCare PPO Dental Insurance Application – Illinois

## UniCare PPO Dental Insurance is available in the following Illinois Counties:

Clinton Cook DeKalb DuPage Jackson Kane	Kankakee Kendall Lake Livingston Madison McHenry	Ogle Peoria St. Clair Will Winnebago
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## UniCare PPO Dental Rates for Illinois Residents

	Monthly Rate	Quarterly Rate
One adult	\$31.00	\$ 93.00
Two adults	\$62.00	\$186.00
Adult with 1 child	\$47.00	\$141.00
Adult with 2 children	\$63.00	\$189.00
Adult with 2+ children	\$87.00	\$261.00
Family (1 child)	\$78.00	\$234.00
Family (2 children)	\$94.50	\$283.50
Family (3+ children)	\$118.50	\$355.50
1 child	\$16.50	\$ 49.50
2 children	\$32.50	\$ 97.50
3+ children	\$57.00	\$171.00

**Download / Print the application form, then complete it by hand.**

It is easy to apply for UniCare individual and family dental insurance.

### Important Considerations:

- Your UniCare dental insurance start date is the first day of the month following receipt of your completed dental insurance application and payment.
- **Billing Type:** You can choose either Monthly Billing (available only through Monthly Bank Draft Authorization) or Quarterly Billing, in which UniCare mails you a billing statement every three months. If you choose Monthly Billing, complete the Monthly Bank Draft Authorization section of the application.
- **A payment must accompany your application.** Provide a one-month payment, which is acceptable even if you choose quarterly billing (UniCare will bill you for the two-month balance). You can pay by check (payable to UniCare) or credit card (Fill out the Initial Payment by Credit Card section of application.).

Return the completed dental insurance application and payment to the following address:

**MedPlan Access  
P.O. Box 2220  
West Lafayette IN 47906**

**Applications cannot be processed without payment. Checks must be payable to “UniCare.”**

### For Faster Processing of Your UniCare Dental Application

To speed up processing of your UniCare dental application, pay by credit card and fax the completed application to MedPlan Access at 765-464-3301.

We will be pleased to review the plan and application with you. Just contact us.

Joe Risse  
MedPlan Access  
1-877-MedPlan (1-877-633-7526)  
joer@medplanaccess.com

**Proceed to Application**





ATTACH CHECK HERE

# UNICARE INDIVIDUAL PPO DENTAL PLAN ENROLLMENT APPLICATION

UniCare Health Insurance Company of the Midwest

Once completed, fax both sides of this form to  
UniCare—Attention: Individual Membership FAX (630) 679-4081

If you are a UniCare subscriber, please enter your current  
UniCare group number and certificate number.

If UniCare approves my application, please  
assign an effective date of the

- 1st of the month following approval.
- \_\_\_\_\_ (mm/dd/yy).

GROUP NO.

CERTIFICATE NO.

**Applicant Information – Applicant must complete this section.**

**Please print**

Last Name		First Name		MI	Social Security No.		
Home Phone No. (      )		Business Phone No. (      )		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Birth
Home Address (Must be complete. P.O. Box not acceptable)				Billing Address (If different or P.O. Box)			
City	State	ZIP Code		City	State	ZIP Code	

**Spouse to be Insured – Signature required below.**

Last Name of Spouse	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mo/Day/Yr)	Social Security No.
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**Children to be Insured**

NAME (First and Last Name)	SEX	BIRTHDATE			SOCIAL SECURITY NO.					
		Mo	Day	Yr						
1	<input type="checkbox"/> M <input type="checkbox"/> F									
2	<input type="checkbox"/> M <input type="checkbox"/> F									
3	<input type="checkbox"/> M <input type="checkbox"/> F									
4	<input type="checkbox"/> M <input type="checkbox"/> F									

**Signatures (Required)**

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the natural parent, please submit court papers authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. I understand that receipt of money with this application does not create UniCare coverage. Coverage will come into effect only on approval by UniCare.

Signature of Applicant / Parent or Legal Guardian <b>X</b>	Today's Date	Signature of Applicant's Spouse <b>X</b>	Today's Date
Signature of Applicant's Dependent Age 18 or over <b>X</b>	Today's Date	Signature of Applicant's Dependent Age 18 or over <b>X</b>	Today's Date

**Agent Information**

Name of Agent (Print) Joe Risse, MedPlan Access	Agent Tax I.D. Number 351938836	Check one <input checked="" type="checkbox"/> EIN <input type="checkbox"/> SS#	Signature of Agent <b>X</b>	Today's Date
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**FOR UNICARE USE ONLY**

Group No.	Certificate No.	Agent Tax I.D. No.	Effective Date	Area	By	Date
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Once completed, fax both sides of this form to UniCare—Attention: Individual Membership FAX (630) 679-4081

### Select Billing Type

Monthly (By checking account deduction only.)  Quarterly

Please choose the draft date on which you would like your premium debited from your checking account:

1st  8th  15th  22nd of the month

## Monthly Bank Draft Authorization

### INSTRUCTIONS:

1. Complete this section.
2. Submit a check for one- (1) month's premium made out to UniCare.

**All funds are drawn on the first of each month. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.**

**OPTIONAL MONTHLY BANK DRAFT AUTHORIZATION.** As a convenience to me, I request and authorize YOU to pay and charge to my account checks drawn on that account by and payable to the order of UniCare provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize UniCare to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my UniCare premium. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

**NOTE TO APPLICANT:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the Monthly Checking Account Deduction option.

**You will incur a service charge for any withdrawal not honored. UniCare must be notified of any changes to your bank account.**

Applicant's Name

Applicant's Social Security No.

Name on Checking Account (If different than above)

Routing No.

Checking Account No.

Name of Bank

Authorized Signature (as it appears in the financial institution's records)

**X**

Date

### Initial Premium Payment by Electronic Check

Select one:  1 month  3 months

Check No. Initial Premium Amount Electronic Check  
\$

Bank/Credit Union Routing No.

Checking Account No. (as it appears on your check)

Name on Account

### Initial Premium Payment by Credit Card

**New members only. Not available to make a coverage change.**

Select one:

1 month  3 months

Initial Premium Amount Credit Card:

\$

Credit Card

VISA  MasterCard

Credit Card No.

Expiration Date

Cardholder's Name

Cardholder's ZIP Code

Authorized Signature (**as it appears on the credit card**)

Today's Date