UniCare PPO Dental Insurance Application – Indiana

UniCare PPO Dental Rates for Indiana Residents		
	Monthly Rate	**Quarterly Rate**
One adult	$26.00	$ 78.00
Two adults	$52.00	$156.00
Adult with 1 child	$39.00	$117.00
Adult with 2 children	$53.00	$159.00
Adult with 2+ children	$72.00	$216.00
Family (1 child)	$65.00	$195.00
Family (2 children)	$79.00	$237.00
Family (3+ children)	$98.50	$295.50
1 child	$13.00	$ 39.00
2 children	$27.00	$ 81.00
3+ children	$46.50	$139.50

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'll 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

UniCare Life & Health Insurance Company

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

If UniCare approves my application, please assign an effective date of the
☐ 1st of the month following approval.
☐ ________________________ (mm/dd/yy).

Attach Check Here

UNICARE INDIVIDUAL PPO DENTAL PLAN ENROLLMENT APPLICATION

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

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	Marital Status	Age	Date of Birth
( )	( )	☐ M ☐ F	☐ Single ☐ Married		

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	Date of Birth (Mo/Day/Yr)	Social Security No.
		☐ M ☐ F		

Children to be Insured

	Name (First and Last Name)	Sex	Birthdate Mo Day Yr	Social Security No.
1		☐ M ☐ F		
2		☐ M ☐ F		
3		☐ M ☐ F		
4		☐ M ☐ 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	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	
Signature of Applicant / Parent or Legal Guardian	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	

Agent Information

Name of Agent (Print)	Agent Tax ID Number	Check One	Signature of Agent	Today's Date
Joe Risse, MedPlan Access	351938836	X EIN ☐ SS #	X	

FOR UNICARE USE ONLY

Group No.	Certificate No.	Agent Tax I.D. No.	Effective Date	Area	By	Date

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(Continued on reverse side)

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)

Checking Account No.

Name of Bank

Routing No.

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) **X**		Today's Date

Insurance coverage underwritten by UniCare Life & Health Insurance Company. ® Registered Mark of WellPoint, Inc. © 2005 WellPoint, Inc.