

Applicant's Social Security No.

--	--	--	--	--	--	--	--	--	--	--	--

Visa/ Passport No.

--

Agent I.D. No. **22566**

Global Citizen Health Plan Individual Enrollment Application

UniCare Life & Health Insurance Company

Application must be completed by the applicant in blue or black ink.

Reason for Application (Check one)

- New Enrollment(s)
- Add dependent(s) to I.D. No: _____
 To change existing plan, please enter I.D. No: _____

1. Applicant Information (Please Print)

Primary Applicant's Last Name	First Name	M.I.
-------------------------------	------------	------

Address Outside the US

Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City	Postal Code	Country	

Address Inside the US

Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City	State	ZIP Code	

Mailing Address (In Care Of)

In Care Of:			
Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City	State	Postal Code	Country

Home Phone No. () () ()	Daytime Phone No. () () ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Business Phone No. () () ()	Fax No. () () ()	Spouse's Social Security/ Visa/ Passport No.
Email Address		Maiden Name of Applicant/Spouse (If applicable)

2. Time and Location Status

How much time in the next 24 months will you be outside of your home country? _____

What locations? _____

3. Choice of Plan

Global Citizen (Includes Benefits in the U.S.) <input type="checkbox"/> Elite <input type="checkbox"/> 500 <input type="checkbox"/> 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 5000 <input type="checkbox"/> 10000 <input type="checkbox"/> 25000 <input type="checkbox"/> HSA 1000 ind. only <input type="checkbox"/> HSA 2000 ind. plus dependent(s)
Global Citizen EXP (Excludes Benefits in the U.S.) <input type="checkbox"/> Elite <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1000 <input type="checkbox"/> 2500 <input type="checkbox"/> 5000 <input type="checkbox"/> 10000
Prescription Drug Rider <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Rider (Elite Plans only) <input type="checkbox"/> Yes <input type="checkbox"/> No

4. Applicants for Coverage

Check one: Insure all eligible applicants Insure no one unless all are accepted for coverage

Please list all applicants applying for coverage. (List children youngest to oldest)

If a family member's last name is different than yours, please attach explanation to application.

**HTH
USE ONLY**

Relation	Last Name	First Name	M.I.	MUST BE ACCURATE		Date of Birth	Social Security/ Visa/ Passport No.	WVR	WVR
				Height	Weight				
<input type="checkbox"/> Male <input type="checkbox"/> Female	Yourself								
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse								
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									

Applicant's Social Security No.

Visa/ Passport No.

4. Applicants for Coverage continued

Applies to couples or families:

All family members must apply for coverage to be eligible. If extenuating circumstances prevent all family members from applying, please attach detail and a determination will be made by the company whether or not the application can be considered.

If you are married or have children, are all family members applying for coverage? Yes No N/A

If No, Why? _____

Are you a U.S. Citizen? Yes No

Are you a foreign national residing legally in the U.S.? Yes No

Please list your occupation and duties.

Please provide the name of your employer.

Please provide your employers address.

5. Other Coverage - Please answer all of the following questions.

A. Do you currently have or has anyone to be insured had coverage in the last 18 months? Yes No

If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

Name of insured(s)	Insurance carrier(s)	Effective date	End date
--------------------	----------------------	----------------	----------

Do you agree to discontinue your current coverage if this application is accepted? Yes No

If No, please explain:

B. Has anyone on this application been insured by UniCare in the last 5 years? Yes No

If Yes, please provide the following information.

Name of insured(s)	Plan/I.D. No.	Group No.	
Name of Plan	City	State	Date cancelled

C. If any applicant has/had UniCare group coverage, please complete the following:

I certify that my UniCare group coverage will end/ended on (date):

I do not wish to enroll in any available Conversion Agreement. I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.

D. Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? Yes No

If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain
3. Name of applicant	Name of Insurance Company	Explain

E. Are any persons applying for coverage on this application eligible for Medicare or Medicaid benefits? Yes No

If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for Global Citizen but may be eligible for Global Citizen EXP.

Eligible person(s)

F. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? Yes No

If Yes, please provide the following information.

Name of applicant	Effective date	End date
-------------------	----------------	----------

Applicant's Social Security No.

--	--	--	--	--	--	--	--	--	--

Visa/ Passport No.

--

6. Health History – Include information on all family members you wish to enroll.

6A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.

Has any person listed on this application received medical advice, diagnosis or treatment, or had treatment or consultation recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **within the last 10 years?**

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis or any other neurological or central nervous system disorder(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Sexually transmitted disease, such as herpes, genital warts, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy or any similar symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction or penile implant <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	19. a) Breast disorder/cyst, lump, fibroid tumors, silicone injections or implants <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever or any other circulatory condition <input type="checkbox"/> Yes <input type="checkbox"/> No	b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, reactive airway disease (RAD), pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	c) Date and result of last pelvic exam/Pap smear for each female over 16: Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> N/A I have not had a pelvic exam/Pap smear.
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring or use of a sleep monitoring device <input type="checkbox"/> Yes <input type="checkbox"/> No	d) Is the applicant, spouse or any dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ (Temporomandibular Joint Dysfunction) <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids or any other digestive disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Diseases or problems of the ears or hearing, implant or hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain or hepatitis (indicate type: _____) <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio or any other musculoskeletal disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation or prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application ever :
13. Diabetes, thyroid, pituitary, adrenal or any other endocrine disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Had cancer, tumor/growth, leukemia or cyst? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Is any applicant a candidate for or a recipient of an organ or bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery or any other skin conditions <input type="checkbox"/> Yes <input type="checkbox"/> No	28. Been diagnosed as having or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT: Applicant's medical conditions, which occur after the signature date and before the approval date that come to HTH Worldwide's attention, may be considered in the final underwriting decision.

Applicant's Social Security No.

Visa/ Passport No.

6B. Professional Services

Give COMPLETE details of any "Yes" answers to the questions in 5A. (Use additional sheets if necessary.)

Table with 5 columns: Question #, Name of Family Member, Date of Onset, Name of Physician/Hospital/Other Facility, Date of Visit. Includes rows for Name of Condition/Illness, Treatment, Results, Medications, and Dosage.

Table with 5 columns: Question #, Name of Family Member, Date of Onset, Name of Physician/Hospital/Other Facility, Date of Visit. Includes rows for Name of Condition/Illness, Treatment, Results, Medications, and Dosage.

Table with 5 columns: Question #, Name of Family Member, Date of Onset, Name of Physician/Hospital/Other Facility, Date of Visit. Includes rows for Name of Condition/Illness, Treatment, Results, Medications, and Dosage.

6C. Prescription Medications -

List all medications not noted above taken within the last 12 months by any family member listed on this application.

Table with 6 columns: Family Member, Medication and Dosage, Illness for which Medication is Prescribed, Date Prescribed, Date Discontinued, Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/ZIP Code.

6D. Other Health Questions

Table with 5 rows of questions regarding tobacco use, illegal drugs, alcohol consumption, and alcohol intake reduction. Includes sub-columns for Family member, Amount per day, and Date Discontinued.

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

Applicant's Social Security No.

Visa/ Passport No.

7. Conditions of Application

It is important that you carefully read and fully understand the following.

I, the undersigned, understand that, under the Global Citizen plan for which I am applying, I may be entitled to lesser benefits if I use a nonparticipating hospital, physician, or other provider, than if I use a participating hospital, physician or other provider.

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section 10, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If, however, you would like to request a specific effective date, we strongly recommend you allow 30-60 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance and will prevent you from being required to pay for two policies.

NOTE: If a child is born to the participant the child has to be registered within 31 days. All other children including adopted children must go through underwriting.

I request that HTH Worldwide assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.

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

1st of the month following approval.

15th of the month following approval.

1st of _____ 15th of _____.

This date must be AFTER the signature date but not greater than 75 days from the signature date on this application.

REQUESTING AN EFFECTIVE DATE **DOES NOT GUARANTEE** UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, ONLY HTH WORLDWIDE CAN CHANGE THIS DATE, HOWEVER, HTH WORLDWIDE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE PLAN IS ISSUED.

Initial X

Initial Term

Please issue coverage for the initial term of:

6 months 7 months 8 months 9 months

10 months 11 months 12 months

(Minimum of six months required.)

Billing Date

Charged on the 1st or 15th of the month (depending on your policy effective date).

Agreement (All applicants)

I, the undersigned, agree to the following:

1. I understand and agree to pay the premium amount required with this application. If my application is denied, HTH Worldwide will return the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.
2. If my application for Global Citizen coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by HTH Worldwide that my application is approved.
3. I understand that HTH Worldwide has the right to deny my application and if it does so, I will be notified in writing and the premium I submitted will be returned.

4. MINOR CHILDREN: I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.
5. CONCERNING DEPENDENTS AGE 18 AND OVER: I represent that my dependents age 18 and over (1) have read this application and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, especially Sections 5A, 5B, 5C and 5D with them and (3) all information contained in this application regarding them is complete and accurate.
6. I understand and agree that if HTH Worldwide rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Receipt of money, and/or cashing of my premium check or charging this amount to my credit card by HTH Worldwide does not constitute approval of my application or create Global Citizen coverage.
7. If I am accepted, this application will become part of the agreement between UniCare and myself.
8. HTH Worldwide may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, HTH Worldwide will determine payment, and I will be responsible for any difference.
9. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policy or terms of any Global Citizen coverage.
10. I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. HTH Worldwide may void all coverage from the original effective date of the agreement for such material intentional misstatements or omissions.
If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.
PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.
11. My insurance agent may receive copies of any correspondence about my medical history when correspondence is required.

Association Membership

I understand that this product is being offered only to members of the Global Citizens Association. I agree to become a member of the Association at no obligation. As a member of the Association, I shall be entitled to a variety of benefits, which includes the ability to purchase this insurance product. For further information visit www.gcassociation.org.

Yes, I Agree X

Signature

Authorization/Disclosure Statement

I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide HTH Worldwide's authorized underwriters or Medical Directors, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below through thirty (30) months. A photocopy of this Authorization is as valid as the original. My authorized representative, insurance agent, or I am entitled to receive a copy of this form.

I understand and agree to all the Conditions of Application (Section 6). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 10). I have read and understand this Application in its entirety. I certify that I have received an outline of coverage.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse (required if applying for coverage)	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

Notice of Information Practices

If you apply for or are covered by an HTH Worldwide health care plan, HTH Worldwide may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. For example, HTH Worldwide may provide information to a hospital in order to verify benefits. Upon your request, HTH Worldwide will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correction if you believe it to be inaccurate. HTH Worldwide can choose to furnish the medical record information either directly to you or to a medical professional designated by you.

Applicant's Social Security No.

--	--	--	--	--	--	--	--	--	--

Visa/ Passport No.

--

ATTACH INITIAL PREMIUM CHECK HERE.
DO NOT TAPE.

8. Payment Method – Submit initial premium with application (required).

8A. Initial Deposit

1 month premium \$ _____

- I am attaching a check/money order for the above amount
- Please charge my credit card for the above amount

3 month premium \$ _____

- I am attaching a check/money order for the above amount
- Please charge my credit card for the above amount

6 month premium \$ _____

- I am attaching a check/money order for the above amount
- Please charge my credit card for the above amount

12 month premium \$ _____

- I am attaching a check/money order for the above amount
- Please charge my credit card for the above amount

All checks should be made payable to HTH Worldwide Insurance Services.

Credit Card information (only if applicable)

- VISA MasterCard American Express Discover

Credit Card No.

Expiration Date

Cardholder's Name

Cardholder's ZIP Code

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

Today's Date

X

8B. Payment Type *(First payment will be credited to approved applicants only.)*

Monthly Deduction

- From Checking Account
- Charge to Credit Card

Quarterly Deduction

- From Checking Account
- Charge to Credit Card

Semi-Annual Deduction

- From Checking Account
- Charge to Credit Card

Annual Deduction

- From Checking Account
- Charge to Credit Card

Checking Account and credit card deductions are done on the first of the month **only**.

8C. Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated or if paying initial premium by credit card, attach a voided check. If the account listed below is a joint account, both account holders' signatures are required. **HTH Worldwide must be notified of any changes to your bank account no later than the 20th of the month preceding the change.**

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 HTH Worldwide provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights with respect to each debit will be the same as if it were a check drawn on you and signed personally by me. I authorize HTH Worldwide to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Global Citizen 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: 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.

Applicant Name	Applicant Social Security No.	Name on Checking Account		
Name of Bank or Financial Institution	Address	City	State	ZIP Code
Checking Account No.	Bank Routing No.	Federal Credit Union Routing No.		
Authorized Signature <i>(as it appears in the financial institution's records)</i>	Date	Authorized Signature <i>(as it appears in the financial institution's records)</i>	Date	

(Continued on reverse)

DO NOT WRITE BELOW