

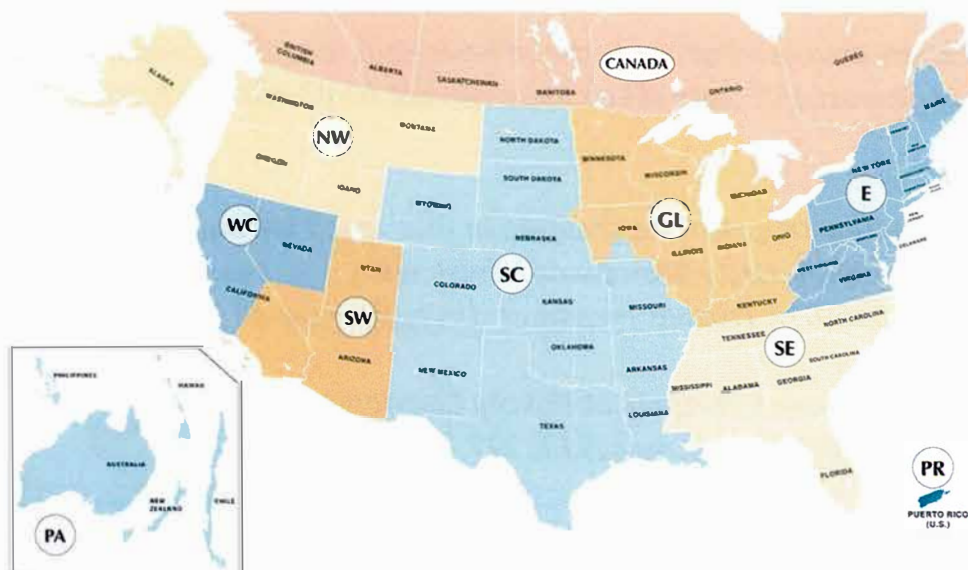


## Exclusive Medical Insurance Program

*Join the UWM Insurance Program to get better and less expensive premiums*

We are excited to announce.... That **Unity Worldwide Ministries** will be offering a full medical insurance program to all our Ministries' full-time employees, (averaging 30 hours or more weekly), Alternative Ministries and their dependents. This insurance program will be available in all 50 states plus Puerto Rico -to include; Major Medical, Dental, Vision, Life, Disability, Critical Illness and Accident insurances. By offering a Group national platform of insurance products, we will be able to offer **better and less expensive insurance** than you could buy as an individual! To make this program successful, we encourage everyone to seriously consider this program. – the more people on the plan the lower the rates!

- There will be one open enrollment period in August- for a starting date of October 1st.
- Anyone that is interested in the major medical **will be required** to fill out a short medical questionnaire. This will be the only chance to sign up until August of 2020.
- You can enroll in any of the plans you choose or none at all. The premiums will be automatically deducted on a monthly basis.
- The more people on the plan the lower the rates!



- 1) **Three major medical plans;**
  - a. \$2,500 Deductible PPO with pharmacy / office visit copays
  - b. \$5,000 Deductible PPO with pharmacy / office visit copays
  - c. \$5,500 High Deductible HSA plan
- 2) **Two Dental plans;**
  - a. \$750 yearly benefit
  - b. \$2,000 Yearly benefit with Orthodontia coverage up to age 19
- 3) **Life Insurance;**
  - a. Whole life
  - b. Voluntary term life
- 4) **Disability Insurance;**
  - a. Short term disability that starts after 14 days of being unable to work
  - b. Long Term disability that starts after 90 days of being unable to work
- 5) **Critical Illness Insurance;**
  - a. Covers most major critical illness's
  - b. Pays out a lump sum of money upon diagnosis
- 6) **Accident Insurance;**
  - a. Yearly benefit of \$2,000
  - b. Reimburses you for the cost of an injury

*\* **To get started** please email [kbukaty@bukaty.com](mailto:kbukaty@bukaty.com) the insurance products you are interested in and the medical questionnaire.*

***Please Stop by the Unity Worldwide Ministries information table at the upcoming convention. We will have more information and you can also pick up the medical application/ let us know what products you are interested in.***

***\*\*We must know your level of interest and have your medical applications back to Bukaty Companies by August 15<sup>th</sup>. Late responders will not be allowed to enroll until August of 2020.\*\****

***For more information or questions feel free to also reach out to;  
Bruce Verkruyse COO – Unity Worldwide Ministries  
John McMahon Board of Trustee Treasurer- Unity Worldwide Ministries***

***or our Strategic insurance partners at Bukaty Companies.***

***Kent Friend - [kfriend@bukaty.com](mailto:kfriend@bukaty.com) (913) 777-7535***

***Or***

***Brad Bukaty [bbukaty@bukaty.com](mailto:bbukaty@bukaty.com) (913) 647-3945***



# 2019 Health Application and Medical Enrollment Form

## Section 1: Employer Information

Employer Name: Unity Worldwide  
 Hire Date: \_\_\_\_\_  
 Employer Address: 400 Unity Way Suite A  
 City: Lee's Summit State: Mo Zip: 64086

## Section 2: Employee Information

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First M.I.  
 Address: \_\_\_\_\_  
City State Zip Job Title  
 Marital Status:  Single  Divorced  Married  Widowed  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Hours Worked per Week: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Business Phone: (\_\_\_\_) \_\_\_\_\_

## Section 3: Other Insurance Coverage

Are you or any dependent(s) disabled  YES  NO If YES, please indicate name(s): \_\_\_\_\_  
 Do you or your spouse have other health insurance?  YES  NO If YES, name of Carrier: \_\_\_\_\_  
*If YES and family member will be covered on the xxx Plan, please complete Coordination of Benefit questionnaire to prevent delay of claims processing.*  
 Policy Holder's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Name of Covered Dependents: \_\_\_\_\_

## Section 4: Subscriber and Dependents (Please complete for employee subscriber and all participating dependents.)

First Name	Last Name	Relationship <small>(Wife, Son, Daughter)</small>	Social Security #	DOB	Age	M / F	Tobacco Use YES / NO
		Employee					

## Section 5: Health Plan Enrollment (Provide a checkmark next to your elected benefit or select decline if you are not electing to enroll.)

I elect to participate  
 I decline participation  
 If declining, provide reason below:

Reason for decline:

Spouse's Employer's Plan  Individual Plan  Medicare  Medicaid  COBRA from Prior Employer

VA Eligibility  I (we) have no other coverage at this time  Other: \_\_\_\_\_

**Coverage Level** (Choose 1)

Employee Only

Employee / Spouse

Employee / Child(ren)

Family

**Plan Selected** (Choose 1)

## Section 6: Health Information

Please furnish us with the height and weight of you and your spouse:

Self: Height \_\_\_ feet \_\_\_ inches; Weight \_\_\_\_\_ lbs Spouse: Height \_\_\_ feet \_\_\_ inches; Weight \_\_\_\_\_ lbs

Please answer the following questions regarding any medical treatment, conditions, or medical treatment for you and your family. If you answer "Yes" to any question please provide detail in space provided below.

1. Have you or any of your dependent(s) been diagnosed or treated for any of the following conditions in the past five (5) years?
 

A. Cardiac Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	H. Aids / Immune System Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Cancer (any form) <input type="checkbox"/> Yes <input type="checkbox"/> No	I. Alcohol / Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	J. Mental / Nervous Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
D. Kidney Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	K. Neuromuscular Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
E. Respiratory Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	L. Stomach / Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No
F. Liver Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	M. Arthritis, Back, Bone, Joint Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
G. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	N. Seizures, convulsions, epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No
  
2. Within the past 5 years, have you or any dependent ever had an application for insurance declined, postponed, rated, or otherwise modified? .....  Yes    No
  
3. Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, prescription management, or hospitalization in the amount of \$5,000 or more?.....  Yes    No  
 If Yes, please provide information on who and for what conditions in space provided below
  
4. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? If Yes please provide information below.....  Yes    No
  
5. Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant?  
 If Yes, please provide due date and detail in space provided below. ....  Yes    No

Question Number	Family Member	Disease / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

6. Prescriptions / Medications – Please list any medications, prescriptions, or injections taken in the last 12 months.

Family Member	Medication / Rx / Injection	Dosage	Medical Condition

**Agreements**

The answers and statements on this Group Enrollment Form are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its Home Office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract

**Medical Authorization**

I authorize any of the following to disclose any data it has on me, my health or on the health of my family. (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical or medically related facility; (3) any insurance company; (4) The Medical Information Bureau; (5) any other organization, institution, or person that has any data on me or my health or on the health of my family. A copy of this shall be as valid as the original.

**Fraud Warning**

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

**Section 7: Signature**

I hereby authorize my employer to deduct contributions towards my benefits. I hereby agree to abide by the terms and conditions of all benefit plan summary documents, which contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. I hereby authorize my healthcare providers to disclose information from my medical records to xxx and xxx's respective carriers to the extent necessary to for underwriting and benefit eligibility. Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the above conditions and declarations.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_