

EMPLOYEE APPLICATION

PLEASE COMPLETE IN INK. Read and complete all of this form. If you need more space, attach a separate sheet of paper. Please use 4 digits for years (e.g. 1998, not 98).

Anthem Life

Anthem Life Insurance Company
P.O. Box 182361
Columbus, OH 43218-2361
800-551-7265 614-433-8880 Fax

SECTION A. TO BE COMPLETED BY EMPLOYER/GROUP

Group Number	Division Number	Class	Requested Effective Date
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SECTION B. APPLICANT INFORMATION

REASON FOR APPLICATION	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change of Status	<input type="checkbox"/> Change of Beneficiary	<input type="checkbox"/> Exercise Portability Option (complete Sections B, F & G)
	<input type="checkbox"/> Change of Coverage	<input type="checkbox"/> Change of Class	<input type="checkbox"/> Change of Name/Address	<input type="checkbox"/> Waive Life Coverages (complete Section H)
Social Security Number	Last Name, First Name, MI		Home Telephone Number ()	
Street Address	City	State/Zip	County	Municipality
Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, state reason:	Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Employer/Group Name	Occupation	Business Telephone	Fax Number	E-Mail Address
Hours worked per week for this employer	Date of hire as Full-time	Current Income	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Income Reported on: <input type="checkbox"/> W-2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other _____

EMPLOYEE AND DEPENDENT DETAILS (Complete all details for individuals applying for coverage; list names of all dependents.)

Last Name, First Name, MI	Social Security Number	Sex	Date of Birth	Age	Relationship	Height	Weight	State of Birth	Eligible for federal income tax exemption?	Full-Time Student?
Employee		M F			self					
		M F								
		M F								
		M F								
		M F								
		M F								

List address of all dependents if different from the applicant, including temporary address, e.g. college student.

Name/Address: _____

Name/Address: _____

Are you or any dependent currently hospitalized? Yes No If yes, list name and reason: _____

SECTION C. STATUS CHANGE

Reason for status change:	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Spouse Deceased	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Termination of Employment
Date Change Occurred:	<input type="checkbox"/> Change Coverage Amount				
<input type="checkbox"/> Change Name To:	Current Benefit Amount: \$				
<input type="checkbox"/> Change Address To:	Change Benefit Amount to: \$				
<input type="checkbox"/> Change of Beneficiary (complete section D)	<input type="checkbox"/> Change Life Class to:				
<input type="checkbox"/> Add/Delete Dependents (include name and date of birth/adoption)					
<input type="checkbox"/> Other Change (explain)					

SECTION D. BENEFICIARY DESIGNATION

Primary Beneficiary:	Name: _____	Age: _____	Relationship: _____
	Name: _____	Age: _____	Relationship: _____
Contingent Beneficiary:	Name: _____	Age: _____	Relationship: _____
	Name: _____	Age: _____	Relationship: _____

SECTION E. INSURANCE COVERAGES (Check all that you are applying for.)

<input type="checkbox"/> Basic Life	<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Basic Accidental Death & Dismemberment (AD&D)	<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Supplemental Life: _____ X earnings or \$ _____	<input type="checkbox"/> Dependent Life: _____ Option: _____
<input type="checkbox"/> Supplemental AD&D: _____ X earnings or \$ _____	<input type="checkbox"/> Voluntary Short Term Disability
	<input type="checkbox"/> Other: _____

SECTION F. PORTABILITY (Complete only if exercising portability option. Attach check with application.)

Date coverage with Employer terminated: _____ Payment Mode Requested: Quarterly Semi-Annual Annual

Coverage Transfer Options: (Minimum employee coverage is \$20,000 and employee coverage is required to transfer any dependent coverage.)

Dependent coverage may not exceed 50% of employee coverage.)

Employee Same Decrease to: _____ Delete coverage
Spouse Same Decrease to: _____ Delete coverage
Children Same Decrease to: _____ Delete coverage

SECTION G. AUTHORIZATION (Read carefully before signing.)

- 1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract, subject to change by my written notice to my employer.
- 2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages if necessary for the required premium for the coverage for which I have applied.
- 3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
- 4. I am applying for the coverage selected on this application. If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
- 5. I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this application form, is valid from the date signed for a period of thirty months. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my children and my spouse (if spouse does not sign below), if covered by the Plan. I am acting as their agent and representative.

SIGNATURE OF APPLICANT _____ DATE _____ SIGNATURE OF SPOUSE (If to be covered) _____ DATE _____

This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: Anthem Life, P.O. Box 182361 Columbus, OH 43218-2361. Such revocation must be signed and dated by the Applicant and spouse, if spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

REFUSAL OF AUTHORIZATION

I refuse authorization to disclose health care information. I understand that such refusal may result in denial of coverage or denial of a claim.

SIGNATURE OF APPLICANT _____ DATE _____ SIGNATURE OF SPOUSE (If to be covered) _____ DATE _____

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefit.

SECTION H. WAIVER OF LIFE COVERAGE

I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Print Employee Name: _____ Social Security Number: _____

Employee Signature: _____ Date: _____

The laws of your state require us to provide you with the following information:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefit.

Note: The Group Policy contains exclusions, limitations, and reductions in disability coverages with other income benefits for which you or your dependents may be eligible. Please read the Group Insurance Certificate you will receive when you become insured for a complete description of coverage and all defined terms.