Employee Application

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

Anthem Life

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).

EMPLOYER USE ONLY

Group no.	Division no.	Class	Request effective date (MM/DD/YYYY)

Section 1. REASON FOR APPLICATION

☐ Event date (MM/DD/YYYY)

☐ New enrollment ☐ Change of class ☐ Exercise portability option (complete Sections 1, 7, and 8)
☐ Change of coverage ☐ Change of beneficiary ☐ Waive Life coverages (complete Section 9)
☐ Change of status ☐ Change of name/address ☐ Other _____

Section 2. APPLICANT INFORMATION

Social security no.	Marital status	Sex	Date of birth (MM/DD/YYYY)
	☐ Single ☐ Married ☐ Divorced ☐ Widowed	☐ M ☐ F	

Last name	First name	M.I.

Street address	City	State	ZIP code	County	Municipality

Are you actively at work? ☐ Yes ☐ No	If no, state reason	Are you retired? ☐ Yes ☐ No

Employer/Group name	Occupation	Date of hire as full-time (MM/DD/YYYY)

Hours worked per week	Current income	Per ☐ Hour ☐ Week ☐ Month ☐ Year	Income reported on ☐ W-2 ☐ 1099 ☐ Other _____

Home phone no.	Work phone no.	Fax no.	E-mail address

Section 3. EMPLOYEE AND DEPENDENT DETAILS. Complete all details for individuals applying for this coverage; list names of all dependents.

Last name, first name, MI	Social security no.	Sex	Date of birth	Age	Relationship	Height	Weight	State of birth	Eligible for federal income tax exception?	Full-time Student?
Employee		☐ M ☐ F			Self					☐ Y ☐ N
		☐ M ☐ F								☐ Y ☐ N
		☐ M ☐ F								☐ Y ☐ N
		☐ M ☐ F								☐ Y ☐ N
		☐ M ☐ F								☐ Y ☐ N
		☐ M ☐ F								☐ Y ☐ N

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

Dependent name	Address	Are you or any depended currently hospitalized?	If yes, reason

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

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Section 4. STATUS CHANGE

Reason for change: ☐ Marriage ☐ Divorce ☐ Spouse deceased ☐ Birth/adoption ☐ Termination of employment

☐ Change name to	Date of change occured (MM/DD/YYYY)
☐ Change address to	Date of change occured (MM/DD/YYYY)
☐ Change of beneficiary (complete Section 5)	Date of change occured (MM/DD/YYYY)
☐ Add/delete dependent (name of dependent)	Date of birth/adpotion (MM/DD/YYYY)
☐ Change coverage amount Current benefit amount: $ _____ Change benefit amount to: $ _____	Date of change occured (MM/DD/YYYY)
☐ Change life class to	Date of change occured (MM/DD/YYYY)
☐ Other change (explain)	Date of change occured (MM/DD/YYYY)

Section 5. BENEFICIARY DESIGNATION

	Name of beneficiary	Social security no.	Relationship to applicant	Age
Primary Beneficiary				
	Name of beneficiary	Social security no.	Relationship to applicant	Age
Contingent Beneficiary	Name of beneficiary	Social security no.	Relationship to applicant	Age
	Name of beneficiary	Social security no.	Relationship to applicant	Age

Section 6. INSURANCE COVERAGE. Check all that you are applying for. Coverage is limited to what is selected and offered by the employer.

☐ Basic Life
☐ Basic AD&D
☐ Dependent Life
☐ Short Term Disability
☐ Long Term Disability
☐ Other _____
☐ Voluntary Short Term Disability (VSTD)
☐ Voluntary Long Term Disability (VLTD)
☐ Voluntary AD&D: _____ x annual earnings OR $ _____

☐ Optional Life (If checked, complete the rest of this section.)
Optional Life: _____ x annual earnings OR $ _____
Optional LIfe (51+ lives only): Spouse $ _____
Child $ _____

Payroll deduction frequency: ☐ Weekly ☐ Semi-monthly ☐ Bi-Weekly ☐ Monthly

Optional AD&D: _____ x annual earnings OR $ _____

Section 7. PORTABILITY. Complete only if exercising portability option. Attach check with application.

Payment mode requested ☐ Quarterly ☐ Semi-annual ☐ Annual	Date coverage with employer terminated

Coverage Transfer Options: (Minimum employee coverage is $10,000 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 8. 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 recission 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.

Employee signature **X**	Date
Spouse signature **X**	Date

Section 9. 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 no.
Employee signature **X**	Date

The laws of some states require us to provide you with the following information:

In Indiana and Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Kentucky:
Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.