

EMPLOYEE APPLICATION

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

AnthemLife



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SECTION A. TO BE COMPLETED BY EMPLOYER/GROUP

Group Number	003756E	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, M.I.	Home Telephone Number ()
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Street Address	City	State/Zip	County	N/A
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Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, state reason:</i>	Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <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
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Employer/Group Name	Occupation	Business Telephone	Fax Number	N/A
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Hours working per Week for this employer:	Date of hire as Full-time:	N/A
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EMPLOYEE AND DEPENDENT DETAILS (Complete all details for individuals applying for coverage; list names of all dependents.)

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

N/A

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 this 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:				

Other Change (explain)

SECTION D. BENEFICIARY DESIGNATION

Primary Beneficiary	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age
Contingent Beneficiary	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age
Contingent Beneficiary	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age

SECTION E. INSURANCE COVERAGES (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:
Optional Life
Optional Life (51+ lives only): Spouse
Child
Payroll Deduction Frequency: Weekly, Bi-weekly, Semi-monthly, Monthly
Monthly Premium Amount:
Optional AD&D:
x annual earnings OR \$

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 the lesser of the amount of coverage in-force or \$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 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.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
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.
5. I understand that Anthem Life Insurance Company 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 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: Date:
Spouse Signature: Date:

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.

Print Employee Name: Social Security Number:
Employee Signature: 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.