

EMPLOYER/GROUP APPLICATION

Anthem Life
ANTHEM LIFE & DISABILITY
INSURANCE COMPANY

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

P.O. Box 182361
 Columbus, OH 43218-2361
 800-551-7265 • 614-433-8880 Fax

SECTION A. ANTHEM LIFE & DISABILITY INSURANCE COMPANY (ANTHEM LIFE) USE ONLY

Group Number	Group Name	Effective Date
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SECTION B. APPLICANT INFORMATION

REASON FOR APPLICATION	<input type="checkbox"/> New Application. <input type="checkbox"/> Change of Address. <input type="checkbox"/> Change of Benefits. <input type="checkbox"/> Reinstatement.	REQUESTED EFFECTIVE DATE:
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The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Voluntary Long Term Disability
<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Voluntary Short Term Disability

Tax Identification/FEIN	Legal Name of Group	Name of Association (if applicable.)
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Head of Firm/Title	Administrative Contact/Title	Years in Business	Number of Full Time Employees
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Home Office Address	City	State/Zip	County	Municipality
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Billing Address (if different from Home Office Address.)	City	State/Zip	Type of Business
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Standard Industry Code (SIC)	Phone Number	Fax Number	E-mail Address	Does group have a cafeteria plan under IRS Section 125? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Type of Organization: <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Labor Union <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Trust <input type="checkbox"/> Government Unit <input type="checkbox"/> Other	Is coverage subject to bargaining agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will bargaining agreement participants be considered eligible employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	Union name, number & contract expiration date: (attach a copy of agreement.)
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Affiliates/Subsidiaries/Divisions to be included: List name, location, and number of employees at each location.

Are separate billings required for subsidiaries/affiliates? Yes No for classes? Yes No (If yes, attach detailed information.)

Has your group been turned down for coverage in the last 12 months? Yes No If yes, by whom, when, why:

SECTION C. ELIGIBILITY AND WAITING PERIOD

Eligible Full-time employees must work at least 30 hours per week, must be actively-at-work, and must satisfy any applicable waiting period.

The waiting period for individuals employed *on or before* the effective date will be:

none ____ days continuous employment. first premium due date following ____ days of continuous employment.

The waiting period for individuals employed *after* the effective date will be:

none ____ days continuous employment. first premium due date following ____ days of continuous employment.

Do any employee classes have a different waiting period? Yes No If yes, please describe:

SECTION D. CONTRIBUTIONS

Group contribution percentage:	Do any employee classes have a different group contribution?
<input type="checkbox"/> Basic AD&D ____%	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
<input type="checkbox"/> Short Term Disability ____%	
<input type="checkbox"/> Optional AD&D ____%	
<input type="checkbox"/> Long Term Disability ____%	

SECTION E. ACTIVELY AT WORK REQUIREMENTS

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Anthem Life & Disability Insurance Company (Anthem Life) may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied. 1) The employee's absence must be due to illness or injury. 2) The employee must be covered by the prior carrier on the day immediately prior to Anthem Life's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Anthem Life's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Name of Employee.	Amount of Insurance.	Date of Birth.	Date Last Worked.	Reason Not Working.	Date Expected To Return.	Insured by Prior Carrier.	Request Actively- At-Work Waiver.	Waiver Request Approved.	Underwriter Approval.
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION F. OPTIONAL AND VOLUNTARY GROUP INSURANCE

Mode of payment: Payroll Deduction Quarterly Semi-Annual Annual *If payroll deduction, bill:* 1/12 Annual Special Frequency
 Is Accidental Death included? Yes No Voluntary Accidental Death & Dismemberment Yes No
 VSTD: Weekly Benefit Amount 50% 60% 66²/₃% 70% or Flat Amount \$ _____ Benefit Duration: 13 weeks 26 weeks
 Small Group (2-50 lives): Elimination Period 1-8 15-15 Large Group (51+): Elimination Period: 1-8 8-8 15-15 30-30
 VLTD: Monthly Benefit Amount 50% 60% Maximum Benefit Amount: \$ _____ Benefit Duration: 2 yrs/RBD 5yrs/RBD To age 65/RBD SSNRA
 Elimination Period: 90 days 180 days Definition of Disability: 2YR Own Occ. 3YR Own Occ. 5YR Own Occ. To age 65 Own Occ. Pre-Ex Limit: 3/6/12 12/6/24

SECTION G. AUTHORIZATION (Read carefully before signing.)

The undersigned employer and/or authorized representative hereby requests that it be approved for insurance coverage through Anthem Life & Disability Insurance Company (Anthem Life). Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums. The authorized representative certifies to all of the following on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem Life or their designated agent(s), any information required in connection with administration of the insurance coverage.
4. To provide notice of applicable conversion rights to eligible employees and eligible dependents.
5. That approval for this insurance may cancel any prior contracts and/or coverage with Anthem Life effective immediately preceding the effective date of the employer's coverage.
6. To pay Anthem Life by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership.
7. That claims filed by or on behalf of members may, at Anthem Life's option, be suspended if premiums are not received timely.
8. Employer will receive, on behalf of members, all notices delivered by Anthem Life, and immediately forward such notices to persons involved, at their last known address, including certificates of coverage.
9. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Anthem Life's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these Conditions are met, there shall be no liability on the part of

- Anthem Life except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
10. That in order for Anthem Life to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem Life, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Life may be different than the coverage applied for herein. In that event, Anthem Life shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
 11. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem Life by the employer. Anthem Life reserves the right to review such rates upon receipt of all individual applications for employers' employees and modify the rates in accordance with our underwriting guidelines as approved by the Superintendent of Insurance for the state of New York, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rate as of the effective date of coverage.
 12. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
 13. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Anthem Life in writing) and meet any other eligibility requirements for coverage.
 14. This application will be part of the policy. The requested coverage is not in effect unless and until this application is approved by Anthem Life. That approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem Life.

ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Authorized Group Representative	City/State where signed	Date
Print Name of Authorized Group Representative	Title of Authorized Group Representative	

Broker Certification

I hereby certify that: (1) I have reviewed the attached employee and group applications and waivers for completeness and accuracy. (2) I am not aware of any health history of any applicant that does not appear on the application. (3) I have not completed any of the information contained in the applications except with permission of the applicant and as noted by my initials on the application. (4) I have not signed any of the applications for a group representative or individual applicant. (5) I have fully explained to the Employer that an employee not actively at work on the policy effective date or their eligibility date will not be covered until such employee returns to active work full-time. (6) I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or a re-rating of the group's premium retroactive to the effective date of coverage, and that coverage shall not be effective until Anthem Life & Disability Insurance Company (Anthem Life) reviews and approves the application and the group receives a written notice and contract from Anthem Life. (7) I am licensed in the state of this group for the types of insurance solicited.

Name of Broker/Agent		Signature of Broker/Agent	
Broker Number	Tax ID Number to be paid	Broker Phone Number	Date
Agency Name (if applicable)		General Agent	Anthem Sales Representative