

EMPLOYEE APPLICATION

AnthemLife 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. TO BE COMPLETED BY EMPLOYER/GROUP

| | | | |
|--------------|-----------------|-------|--------------------------|
| Group Number | Division Number | Class | Requested Effective Date |
|--------------|-----------------|-------|--------------------------|

SECTION B. APPLICANT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| REASON FOR APPLICATION | <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Change of Status | <input type="checkbox"/> Change of Coverage | <input type="checkbox"/> Change of Class | <input type="checkbox"/> Change of Name/Address |
| Social Security Number | Last Name, First Name, M.I. | | Home Telephone Number () | | |
| Street Address | City | State/Zip | County | Municipality | |
| 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 | | |
| Employer/Group Name | Occupation | Business Telephone | Fax Number | E-mail Address | |
| Hours working 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 DETAILS (Complete all details for individuals applying for coverage.)

| Last Name, First Name, M.I. | Social Security Number | Sex | Date of Birth | Age | Height | Weight | State of Birth |
|-----------------------------|------------------------|--|---------------|-----|--------|--------|----------------|
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | |

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 | <input type="checkbox"/> Change Coverage Amount: Current Benefit Amount: \$ _____ Change Benefit Amount to: \$ _____ |
| Date Change Occurred: | |
| <input type="checkbox"/> Change Name to: | |
| <input type="checkbox"/> Change Address to: | |
| <input type="checkbox"/> Other Change (explain): | |

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

Coverage is limited to what is selected and offered by the employer.

| | |
|--|--|
| <input type="checkbox"/> Basic AD&D | <input type="checkbox"/> Voluntary AD&D: _____ x annual earnings OR \$ _____ |
| <input type="checkbox"/> Short Term Disability | <input type="checkbox"/> Voluntary Short Term Disability (VSTD) |
| <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> Voluntary Long Term Disability (VLTD) |
| Voluntary Payroll Deduction Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly | |
| Monthly Premium Amount: \$ _____ | |

SECTION E. AUTHORIZATION (Read carefully before signing.)

- 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.
- I am responsible for the timely notification to my employer of any changes that would make me ineligible for coverage.
- 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.
- I understand that Anthem Life & Disability 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 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). I agree that this application will be part of the certificate.

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

Employee Signature: _____ *Date:* _____

SECTION F. WAIVER OF COVERAGE

I hereby certify that I have been given the opportunity to apply for the available group 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 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:* _____

Notice: This plan contains a pre-existing condition exclusion. A pre-existing condition is any condition where symptoms would ordinarily cause a prudent person to seek diagnosis, care or treatment, within the policy specified period prior to becoming insured. No benefit will be payable during the first 12 consecutive months after the Insured's effective date of coverage for any Disability which is caused by, contributed to by, or resulting from a pre-existing condition.