

# EMPLOYEE APPLICATION

*Anthem*Life

**ANTHEM LIFE & DISABILITY INSURANCE COMPANY**

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## 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
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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 Coverages	<input type="checkbox"/> Reinstatement
	<input type="checkbox"/> Late Enrollment	<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					

Are you currently hospitalized?  Yes  No *If yes, list 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	<input type="checkbox"/> Change Coverage Amount:
Date Change Occurred:	Current Benefit Amount: \$ _____
<input type="checkbox"/> Change Name to:	Change Benefit Amount 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. (If VSTD, VLTD or VAD&D is checked, complete section E)

<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. MEDICAL INFORMATION

All persons applying for coverage must complete Section E, Part 1. You must complete Section E, Part 2 if you have answered "Yes" to any question in Part 1, you are enrolling past the open enrollment period, you are applying for Voluntary Insurance and/or Optional insurance or the underwriting department has requested you to do so.

#### PART 1

1. Do you or any of your dependents regularly take medication (prescription or other)? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. To the best of your knowledge and belief, in the last ten years, have you or any of your dependents been diagnosed or received treatment for any: heart/circulatory condition; cancer; Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC); stroke; diabetes (list type below including age at onset & treatment); mental or nervous disorder, depression, kidney, liver or pancreas disorder, emphysema; ulcerative colitis; Crohn's disease; aneurysm; lupus; lung disorder or Chronic Obstructive Pulmonary Disease (COPD); or rheumatoid arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or any of your dependents been told by a Physician that surgery or special medical tests or treatment might be required or necessary at some future date? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Are you or any of your dependents currently pregnant? If yes, list name and due date: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**PART 2**

- |  |  |
|--|--|
| <p>1. To the best of your knowledge and belief, have you or any of your dependents, within the last 10 years, had a diagnosis of or treatment for the following:</p> <p>a. Leukemia, tumor, growths or any diseases of the skin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Ulcers, stomach disorders, hernia, hemorrhoids, diverticulitis, rectal disorder, irritable bowel syndrome or other intestinal disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Thyroid, goiter, gallbladder or prostate disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Disorder of the blood or immune system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. High blood pressure, elevated cholesterol or triglycerides? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Heart attack, angina, heart murmur, anemia, chest pain or any disorder of the heart, arteries, veins or circulatory system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Arthritis, gout, polio, rheumatic fever, multiple sclerosis, muscular dystrophy, carpal tunnel syndrome, disorder of the muscles, back or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Bronchitis, asthma, sinus or nasal disorder, allergies, pneumonia, or any other disorder of the lungs or respiratory system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>i. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. Alcoholism, drug abuse, or attended alcohol or drug dependency organization meetings, or been convicted of DUI/DWI? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Any sexually transmitted diseases or disorder of the genital, reproductive or urinary system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. Any disorder of the eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you or any of your dependents had an inpatient admission and/or inpatient or outpatient surgery; medical or surgical advice; or a condition not identified above, during the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you or any of your dependents, within the last two (2) years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane, or are any such activities contemplated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you or any of your dependents used tobacco products (including cigarettes) in the last twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you or any of your dependents presently disabled or unable to perform their duties? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

**EXPLAIN "YES" ANSWERS TO ANY QUESTION(S) IN SECTION E. GIVE COMPLETE DETAILS. ATTACH SEPARATE SHEETS, IF NECESSARY.**

Question	Person	Diagnosis/Treatment	Dates of treatment	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Length of Stay	Degree of Recovery
	Health Provider	Address	City	State	Zip Code	Telephone Number	

  

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**SECTION F. AUTHORIZATION (Read carefully before signing.)**

- Authorization to release information:

I authorize any of the entities listed herein to give Anthem Life & Disability Insurance Company (Anthem Life), and through it, to its affiliates and any administrators, reinsurers, agents, or other entities providing services on behalf of Anthem Life, any data or records in the entities possession about me (or any dependents listed herein), and my mental or physical health (or that of any dependents listed herein).

This authorization is for: any medical practitioner; hospital; clinic or other medically related facility or provider of health services; insurance company; or any other organization, institution, or person that has data on me or my health. This authorization is valid for two years from the date of this authorization. A photographic or facsimile copy of this form will be as valid as the original. (The person who signs this form may have a copy of it upon request).

The information gathered will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. I understand that Anthem Life may furnish this information to the group or its representative. Anthem Life may also furnish information to other entities, which may include but is not limited to third party administrators, insurers, and government agencies. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to diagnosis and treatment of AIDS or ARC, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I have received and read a copy of Anthem Life's Notice of Information Practices (as contained herein).

I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my authorization. I also understand that I have a right to see and correct personal information that Anthem Life collects about me.
- Unless otherwise provided herein, if one or more 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.

3. 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.
4. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
5. 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.
6. 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). This authorization, for purposes of processing this application form, is valid from the date signed for a period of twenty-four months. A photocopy is as valid as the original. 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

*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: \_\_\_\_\_

### **SECTION G. 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.