Employer/Group Application

Anthem Life
ANTHEM LIFE & DISABILITY INSURANCE COMPANY
P.O. Box 182361
Columbus, OH 43218-2361
800-551-7265 ● 614-433-8880 Fax

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).

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

Group Number	Group Name	Effective Date

SECTION B. APPLICANT INFORMATION

REASON FOR APPLICATION: ☐ New Application ☐ Change of Address ☐ Change of Benefits ☐ Reinstatement

REQUESTED EFFECTIVE DATE:

.☐ Basic Life ☐ Dependent Life ☐ Optional Life

Tax Identification/FEIN	Legal Name of Group	Name of Association (if applicable)

Head of Firm/Title	Administrative Contact/Title	Years in Business	Number of Full Time Employees

Home Office Address	City	State/Zip	County	Municipality

Billing Address (*if different from Home Office Address)*	City	Sate/Zip	Type of Business

Standard Industry Code (SIC)	Phone Number	Fax Number	E-mail Address	Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Type of Organization: ☐ Partnership ☐ Corporation ☐ Labor Union ☐ Sole Proprietorship ☐ Trust ☐ Government Unit ☐ Other	Is coverage subject to bargaining agreement? ☐ Yes ☐ No	Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No	Union name, number & contract expiration date: (*attach a copy of agreement)*

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:

☐ Basic Life _____% ☐ Optional Life _____% ☐ Dependent Life _____%

Do any employee classes have a different group contribution? ☐ Yes ☐ No
If yes, please describe:

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*
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

SECTION F. OPTIONAL AND VOLUNTARY GROUP INSURANCE

☐ Optional Life: Mode of payment: ☐ Payroll Deduction ☐ Quarterly ☐ Semi-Annual ☐ Annual *If payroll deduction, bill:* ☐ 1/12 Annual ☐ Special Frequency

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; and the authorized representative certifies 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 for losses incurred after the premium due date 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. The employer understands that the coverage issued by Anthem Life may be different than the coverage applied for herein. Any change in coverage will not be made without the policyholder's written consent.
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 attached to and made 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.

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

Life and Disability products are underwritten by Anthem Life & Disability Insurance Company. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.