

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
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SECTION B. APPLICANT INFORMATION

REASON FOR APPLICATION: New Enrollment Change of Status Change of Beneficiary Exercise Portability Option (complete Sections B, F & G)
 Change of Coverage Change of Class Change of Name/Address 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	Municipality
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Are you actively at work? Yes No *If no, state reason:* _____
 Are you retired? Yes No
 Gender: Male Female
 Marital Status: Single Widowed Married Divorced

Employer/Group Name	Occupation	Business Telephone	Fax Number	E-mail Address
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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 _____
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Do you have any existing life insurance or annuity contracts with this or any other company? Yes No

Will the purchase of this insurance result in the replacement, termination or change in value of any existing life insurance or annuity with this or any other company? Yes No

If "yes" provide information below for each policy or contract being replaced and attach any applicable replacement forms:

Insurance Company Name	Policy/Contract No.	Type of Insurance Being Replaced

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		M F			self					
		M F								
		M F								
		M F								
		M F								
		M F								

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: Marriage Divorce Spouse Deceased Birth/Adoption Termination of Employment

Date Change Occurred: _____ Change Coverage Amount:

Change Name to: _____ Current Benefit Amount: \$ _____

Change Address to: _____ Change Benefit Amount to: \$ _____

Change of Beneficiary (complete section D) Change Life Class to: _____

Add/Delete Dependents (include name and date of birth/adoption)

Other Change (explain) _____

