

EMPLOYEE APPLICATION

Anthem[®]Life

ANTHEM LIFE & DISABILITY INSURANCE COMPANY

EMPLOYEE APPLICATION

AnthemLife
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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 Beneficiary	<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	<input type="checkbox"/> Waive Life Coverages (<i>complete Section H</i>)	

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? <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
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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		<input type="checkbox"/> M <input type="checkbox"/> F			Self					
		<input type="checkbox"/> M <input type="checkbox"/> F								
		<input type="checkbox"/> M <input type="checkbox"/> F								
		<input type="checkbox"/> M <input type="checkbox"/> F								
		<input type="checkbox"/> M <input type="checkbox"/> 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:	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Spouse Deceased	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Termination of Employment
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Date Change Occurred:	<input type="checkbox"/> Change Coverage Amount:
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<input type="checkbox"/> Change Name to:	Current Benefit Amount: \$ _____
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<input type="checkbox"/> Change Address to:	Change Benefit Amount to: \$ _____
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<input type="checkbox"/> Change of Beneficiary (<i>complete section D</i>)	<input type="checkbox"/> Change Life Class to:
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<input type="checkbox"/> Add/Delete Dependents (<i>include name and date of birth/adoption</i>)

<input type="checkbox"/> Other Change (<i>explain</i>)
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Life and Disability products are underwritten by Anthem Life & Disability Insurance Company. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Question	Person	Diagnosis/Treatment	Dates if 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	
Question	Person	Diagnosis/Treatment	Dates if 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	

SECTION G. AUTHORIZATION (Read carefully before signing.)

- Authorization to release information:
 I/We 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 (as authorized by his or her signature below), and my mental or physical health or that of any dependents (as authorized by his or her signature below), except drug and alcohol treatment information. This authorization is for: any medical practitioner; hospital; clinic or other medically related facility or provider of health services; insurance company; the Medical Information Bureau and its members or affiliates; any consumer reporting agency; or any other organization, institution, or person that has data on me or my health or about my dependent or dependent's health (where authorized). 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(s) who signs this form may have a copy of it upon request). I/We understand that, upon written request, I/We may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. The information gathered will be used for purposes which include: 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/We 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 third party administrators, insurers, government agencies and any other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I/We may authorize. 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, reproductive health, information relating to AIDS, 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, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I/We have received and read a copy of Anthem Life's notices about 1) Fair Credit Reporting Act; 2) the Medical Information Bureau; and 3) the Notice of Information Practices Anthem Life is authorized to obtain an Investigative Consumer report on me. I/We understand that I/We may ask to be interviewed for this report. I/We understand that an Investigative Consumer report may be made. I/We hereby authorize such a report. I/We also understand that I/We have a right to see and correct personal information that Anthem Life collects about me, and that I/We may receive a more detailed description of my rights under this law by writing to Anthem Life.
- Unless otherwise provided herein, if one or more life insurance 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.
- 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 or a dependent 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 I will have the opportunity to review any amendments.
- 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, other than the exercise of the portability of insurance option, if applicable, 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 found in this application may result in an otherwise valid claim to be denied under any insurance issued from this application. This authorization, for purposes of processing this application form, is valid from the date signed for a period of twenty-four months. I may revoke this authorization at any time by sending a written request to the Insurer. A photocopy is as valid as the original. I agree that this application will be attached to and made part of the certificate.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Payment of accelerated death benefits reduce life coverage amounts only by the amount of accelerated benefit paid. The Insurer does not discount or charge separate premiums or fees for accelerated death benefits.

Employee Signature: _____ *Date:* _____

Spouse Signature: _____ *Date:* _____

Dependent Child: _____ *Date:* _____
(if over the age of 14 years, 6 months)

SECTION H. WAIVER OF LIFE COVERAGE

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