EMPLOYEE APPLICATION

Anthem® Life

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PLEASE COMPLETE IN INK. Read and complete all of this form. If you need more space, attach a separate sheet of paper. Please use 4 digits for years (e.g. 1998, not 98).

SECTION A. TO BE COMPLETED BY EMPLOYER/GROUP

Group Number	Division Number	Class	Requested Effective Date

SECTION B. APPLICANT INFORMATION

REASON FOR APPLICATION: ❑ New Enrollment ❑ Change of Status ❑ Change of Beneficiary ❑ Change of Coverages ❑ Reinstatement ❑ Late Enrollment ❑ Change of Class ❑ Change of Name/Address ❑ Waive Life Coverages *(complete Section J)*

Social Security Number	Last Name, First Name, MI		Home Telephone Number ( )

Street Address	City	State/Zip	County	Municipality

Are you actively at work? ❑ Yes ❑ No *If no, state reason:*	Are you retired? ❑ Yes ❑ No	Sex ❑ Male ❑ Female	Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced

Employer/Group Name	Occupation	Business Telephone	Fax Number	E-Mail Address

Hours worked per week for this employer	Date of hire as Full-time	Current Income	Per: ❑ Hour ❑ Week ❑ Month ❑ Year	Income Reported on: ❑ W-2 ❑ 1099 ❑ Other ____

EMPLOYEE AND DEPENDENT DETAILS *(Complete all details for individuals applying for coverage; list names of all dependents.)*

Last Name, First Name, MI	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 status 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)*

SECTION D. BENEFICIARY DESIGNATION

Primary Beneficiary: *Name:* _____ *Age:*____ *Relationship:* _____

Name: _____ *Age:*____ *Relationship:* _____

Contingent Beneficiary: *Name:* _____ *Age:*____ *Relationship:* _____

Name: _____ *Age:*____ *Relationship:* _____

SECTION E. LIFE INSURANCE COVERAGES *(Check all that you are applying for.)*

❑ Basic Life

❑ Basic Accidental Death & Dismemberment (AD&D)

❑ Supplemental Life: ____X earnings or $_____

❑ Supplemental AD&D: ____X earnings or $_____

❑ Short Term Disability

❑ Long Term Disability

❑ Dependent Life: Option *(if applicable)*: _____

❑ Other: _____

❑ Voluntary Group Term Life
(if yes, complete the rest of this section and Section F)
Amount of Insurance Requested: $ _____
Amount of Insurance Requested for Spouse: _____ $
Amount of Insurance Requested for Child: ❑ $5,000 ❑ $10,000
Payroll Deduction Frequency:
❑ Weekly ❑ Bi-weekly ❑ Semi-Monthly ❑ Monthly
Monthly Premium Amount: $ _____

❑ Voluntary Short Term Disability
(if yes, complete the rest of this section and Section F)

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

SECTION F. MEDICAL INFORMATION

All persons applying for coverage must complete Section F, Part 1. You must complete Section F, Part 2 if you have answered "Yes" to any question in Part 1, you have fewer than 20 people in your group, you are enrolling past the open enrollment period, you are applying for Voluntary 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)? ❑ Yes ❑ 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? ❑ Yes ❑ No
3. Are you or any of your dependents currently pregnant? If yes, list name and due date: ❑ Yes ❑ No

4. 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 of onset & treatment); mental or nervous disorder, depression, kidney, liver or pancreas disorder, emphysema; ulcerative colitis; Chrohn's disease; aneurysm; lupus; lung disorder or Chronic Obstructive Pulmonary Disorder (COPD); or rheumatoid arthritis? ❑ Yes ❑ No

PART 2

1. To the best of your knowledge, have you or any of your dependents, within the last 10 years, had a diagnosis of or treatment for the following:
   a. Leukemia, tumor, growths or any diseases of the skin? ❑ Yes ❑ No
   b. Ulcers, stomach disorders, hernia, hemorrhoids, diverticulitis, rectal disorder, irritable bowel syndrome or other intestinal disorder? ❑ Yes ❑ No
   c. Thyroid, goiter, gallbladder or prostate disorder? ❑ Yes ❑ No
   d. Disorder of the blood or immune system? ❑ Yes ❑ No
   e. High blood pressure, elevated cholesterol or triglycerides? ❑ Yes ❑ No
   f. Heart attack, angina, heart murmur, anemia, chest pain or any disorder of the heart, arteries, veins or circulatory system? ❑ Yes ❑ No
   g. Arthritis, gout, polio, rheumatic fever, multiple sclerosis, muscular dystrophy, carpal tunnel syndrome, disorder of the muscles, back or joints? ❑ Yes ❑ No
   h. Bronchitis, asthma, sinus or nasal disorder, allergies, pneumonia, or any other disorder of the lungs or respiratory system? ❑ Yes ❑ No
   i. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system? ❑ Yes ❑ No
   j. Alcoholism, drug abuse, or attended alcohol or drug dependency organization meetings, or been convicted of DUI/DWI? ❑ Yes ❑ No
   k. Any sexually transmitted diseases or disorder of the genital, reproductive or urinary system? ❑ Yes ❑ No
   l. Any disorder of the eyes, ears, nose or throat? ❑ Yes ❑ No
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? ❑ Yes ❑ No
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? ❑ Yes ❑ No
4. Have you or any of your dependents used tobacco products (including cigarettes) in the last twelve months? ❑ Yes ❑ No
5. Are you or any of your dependents presently disabled or unable to perform their duties? ❑ Yes ❑ No

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

	Person	Diagnosis/Treatment	Dates of Treatment	Hospitalized Yes No	Surgery Yes No	Length of Stay	Degree of Recovery
Question							
	Health Provider	Address	City	State		Zip Code	Telephone Number
Question							
	Health Provider	Address	City	State		Zip Code	Telephone Number
Question							
	Health Provider	Address	City	State		Zip Code	Telephone Number

Family physician last seen by you and/or your dependents.

	Physician Name	Address	City	State	Zip Code	Telephone Number
Applicant						
Spouse						
Child(ren)						

SECTION G. NOTIFICATION *(Read carefully before signing.)*

Pre-Notice Regarding the Medical Information Bureau: The underwriting process is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including statements in the application and reports we obtain from doctors or medical facilities where you have been attended. Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau, Inc., a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information in its file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. We, or our reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services to Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information 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 HIV virus or 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, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. 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, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.
2. 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.
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 selections(s) is hereby automatically amended to be consistent with the employer's application.
6. I understand that Anthem Life 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 recission 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 thirty months. A photocopy is as valid as the original.

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:* _____

Spouse Signature: _____ *Date:* _____

SECTION J. 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:* _____

The laws of some states require us to provide you with the following information:

In Indiana and Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Kentucky: Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance 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.

Schedule of Premium Rates

Voluntary Group Term Life Insurance Monthly Rates per $1,000 of Death Benefit. Employee and Spouse Rates.

Age (Last Birthday)	Non-Tobacco Use	Tobacco Use (Smoker)
Under 20	.09	.15
20-24	.09	.15
25-29	.09	.15
30-34	.09	.15
35-39	.12	.21
40-44	.22	.35
45-49	.35	.59
50-54	.61	1.00
55-59	1.10	1.84
60-64	1.48	2.31
65-69	1.79	2.68
70-74	3.61	5.13
75-79	6.41	8.17
80 & above	9.39	11.26

Voluntary Group Term Life Insurance Children's Benefits Rates

Plan	Coverage Amount*	Monthly Premium*
Plan 1	5,000	.85
Plan 2	10,000	1.70

*This monthly premium covers all eligible Dependent children. Dependent children age 0-14 days are not eligible for a death benefit. Eligible Dependent children age 15 days to 6 months are limited to a $500 death benefit.

Sample Premium Calculation

The following steps are required to calculate the monthly premium.

1. Find the appropriate monthly rate from the rate chart on the reverse side. You will need to know:
   - What is the actual age of the applicant?
   - Does applicant use tobacco products in any form?

2. Multiply by the units of insurance (1 unit for each $1000 of death benefit).

Example: **Male age 35** **Does not use tobacco products** **Requesting $50,000 death benefit**
Premium Calculation: **.13 (monthly rate per $1000)** **x 50 (units in $50,000 death benefit)** **$6.50 (monthly premium)**

Premium calculations for reduced benefit amounts will be based on the reduced death benefit amount, not the original issue amount.

Example: **The 35-year-old male above turned age 65. His death benefit will reduce to 65% of the original issue amount.**
$50,000 (original death benefit) **x .65 (reduction percentage)** **$32,500 (reduced death benefit)** **1.85 (monthly rate per $1000)** **x 32.5 (units in $32,500 death benefit)** **$ 60.13 (monthly premium)**

If an employee's coverage becomes effective at age 65 or after, reductions will not begin until the next group anniversary date.

Example: **Female age 72** **Does not use tobacco** **Approved for $50,000 death benefit**	**At Group Anniversary:** **$50,000 (original death benefit)** **x .40 (reduction percentage)** **$20,000 (reduced death benefit)** **3.67 (monthly rate per $1000)** **x 20 (units in $20,000 death benefit)** **$ 73.40 (monthly premium)**
At issue: **3.67 (monthly rate per $1000)** **x 50 (units in $50,000 death benefit)** **$183.50 (monthly premium)**	