Participating Unit Page (Employer Application)

1. **Client's Name:** ______________________________ **Tax ID Number:** ____________________
2. **Requested Effective Date:** ____________________ **ISMA Membership Confirmed?** ___Yes ___No
3. **Client's Physical Address:** ____

   ____
4. **Phone Number:** ______________________________ **Fax Number:** ______________________________
5. **Management Contact:**______________________________ **Email:**______________________________
6. All employees are eligible for MEDICAL/DENTAL insurance if they work a minimum of _________ hours per week. (Lowest= 20)
   All employees are eligible for TERM LIFE insurance if they work a minimum of _________ hours per week. (Lowest= 20)
   Every employee working the minimum hours per week stated above must complete an Application; those waiving coverage need complete only sections 1, 2, 5, and 12 (and 4, 7 and 11 if the term life benefit is provided to ALL full-time employees).

7.

1 Total eligible employees working minimum hours/week (see item 6, above)	
2 Less: Number of employees waiving coverage because covered by spouse	-
3 Net eligible employees	
4 Less: Number of employees waiving coverage and not covered by spouse	-
5 Number of employees enrolling (This number must be 75% or more of line 3, above)	

8. Name of Previous Health and/or Life Carrier/Plan Administrator: ______________________________ ____ No previous carrier

9. Employer contribution toward premiums: MEDICAL/DENTAL: ________% Employee ________% Dependent
   (Basic Term Life and Dependent Life are non-contributory) TERM LIFE: ___100___% Employee ___100___% Dependent

10. Probationary Period for New Employees; coverage begins first day of month following end of this period:
    MEDICAL/DENTAL: Physicians: 0 days Employees: ___30 days ___60 days ___90 days ___0 days ___date of hire
    TERM LIFE: Physicians: 0 days Employees: ___30 days ___60 days ___90 days ___0 days ___date of hire

11. Waive Probationary Period for all employees recently hired before the effective date of your group plan? ___Yes ___No

12. Basic Term Life and AD&D Benefit provided to: ___All full-time staff ___Only those taking medical coverage

Please attach 1) copy of most recent billing statement from previous carrier (if applicable), and 2) Tax and Wage statement.

BENEFITS	**Physicians** check one: ☐All plans are available OR ☐ standard Medical & Dental option below:	**Employee**
Medical	Plan Name:	Plan Name:
Dental	____Yes ____No	____Yes ____No
Basic Term Life & AD&D	Benefit Amount: $	Benefit Amount: $
Dependent Life	Benefit Amount: $5,000 on each eligible dependent (provided at no charge if Basic Term Life & AD&D is purchased)	Benefit Amount: $5,000 on each eligible dependent (provided at no charge if Basic Term Life & AD&D is purchased)

Signatures below illustrate an understanding that the ISMA Plan is being offered based upon information provided to Anthem Blue Cross Blue Shield/Anthem Life. Group rates quoted are valid for 10, 11 or 12 months based on enrollment month and will be adjusted, if necessary, based upon the results of the ISMA Plan renewal which occurs each year. Anthem reserves the right to re-rate the group if the number of employees enrolling listed on this form changes by more than 10% within 31 days after the effective date.
The Executive's signature below confirms the acceptance of all information and coverage you have selected.

______________________________ ______________________________
Executive name typed/printed Agent's name typed/printed

______________________________ ______________________________
Executive signature **(Sign *after* underwriting)** Agent Signature **(Sign *before* underwriting)**

Date: ______________________________ Date: ___________ CSR:______________________________

UNDERWRITING ACTION

Effective Date: ________________ Risk Class: _________ Acct #: _________________

Date of Underwriting Action: ___________________ Underwriter's Initials: ___________

AGENT: Please initial below to confirm group's acceptance of final offer then fax this form to Lola Smith at 317-287-8711 within ten (10) business days of the Date of Underwriting Action. Please note that this confirmation finalizes Benefits specified above.

Agent's Initials: _____________

Form updated 05/04/2007