Insurance ISMA Agency

322 Canal Walk • Indianapolis, IN 46202-3268

(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

To request a quote, please complete and return the following:

(1) **Authorization** for ISMA Insurance Agency to obtain quote for Medical Practice Consortium sponsored Anthem and/or Anthem Small Group Plan;

(2) **Anthem Group Enrollment Form** – Required information (highlighted);

(3) **One Anthem Enrollment Application for every employee working at least 30 hours per week** – employees *applying for coverage* complete Sections 1, 2 (New enrollment), 4-11; employees *waiving coverage* complete Sections 1, 2 (Waiver), 5-7, 12.

When all forms are completed, scan and email them to jenderle@ismanet.org, or fax them our private fax line, (317) 261-2238.

Upon receipt, we will review the forms to be sure they are complete, and follow up to collect any missing information. We will then forward them to Anthem Underwriting for review and rating. Finally, we will email firm rates for each plan option for your consideration.

If you have any questions, please email John Enderle at jenderle@ismanet.org or call John at (317) 454-7732.

Authorization for ISMA Insurance Agency to obtain quote for ISMA-sponsored Anthem and/or Anthem Small Group Plan

I authorize ISMA Insurance Agency to obtain a quote for Medical Practice Consortium sponsored Anthem group health insurance or an Anthem Small Group plan for:

Employer Name

Signature of Authorized Signer Date

Name of Authorized Signer

Associations, Trusts and PEOs Group Enrollment Form

Anthem BlueCross BlueShield

AnthemLife

Association/Trust/PEO name
N/A

Client ID no. (if applicable)

To obtain a proposal:

All groups should complete all **highlighted fields**. Provide additional information based on the underwriting category.

Medically Underwritten Groups:

- **Complete** required fields on the front of this form.
- **Employees** must complete ***Section 3: Medical/Information*** of the Enrollment Application.

Non-Medically Underwritten Groups:

- **Complete** required fields on the front of this form.
- **Employees** applications are **not** required with a request for proposal. All parts of the Employee Application excluding ***Section 3: Medical/Information*** must be completed with a sold case submission.
- **Provide** additional information in section 4 on the back of this form.

Section 1: Group Information

Group name			Number of years in business	Medically underwritten ☑ Yes ☐ No	
Street address		City		State	ZIP code
Effective date	SIC code 8011	Primary group contact name	Phone no.	Fax no.	
Group tax ID no.		Email address			

Section 2: Eligibility

Employees are eligible for health insurance if they work a **minimum of 30 hours per week**.
Important: Every employee working the minimum hours/week must complete an application; those waiving coverage should sign the waiver at end of form.

1. Total number of employees working minimum hours/week			
2. Number of employees waiving coverage due to spousal coverage			
3. Subtract number 2 from number 1	Number 1 – number 2 =		= Number of eligible employees
4. Number of employees waiving coverage and not covered by spouse			
5. Subtract number 4 from number 3	Number 3 – number 4 =		= Number of employees enrolling
6. Divide number 5 by number 1. This result must be at least 50% otherwise the group is not eligible for coverage under the plan.	Number 5 ÷ number 1 =		
7. Divide number 5 by number 3. This result must be at least 75% otherwise the group is not eligible for coverage under the plan.	Number 5 ÷ number 3 =		

The following documents are required with the submission of the confirmed *Group Enrollment Form*:

- Group's Census
- A copy of the prior carrier's premium billing
- Completed employee enrollment forms

Will Life AD&D be offered to those not enrolling in the medical? ☐ Yes ☐ No

Employer contribution – If employer pays 100% of premium all eligible employees must enroll.
Medical: _____ % Employee _____ % Dependents Life AD&D: _____ % Employee

Probationary period for new employees
The day after: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
First billing date after: ☐ 0 days ☐ 30 days ☐ 60 days

Return from leave or layoff
Employees returning from a leave of absence or lay off within 63 days will be made effective on the first day of the month following rehire. If more than 63 days has elapsed between date of termination of the group coverage and the rehire date, the probationary or service waiting period will apply.

Employee terminations – Coverage will be terminated:
☑ Last day of the month ☐ Last day worked

Reset Form

Save and Print

Section 3: Benefits Requested

Medical				
Plan 1: To be determined after risk class is assigned	Plan 2:			
Dental	Voluntary	Ortho	Stand-alone	Mixed enrollment
Plan 1:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 2:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 3:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vision		Voluntary	Stand-alone	Mixed enrollment
Plan 1: High Option		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 2: Low Option		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section 4: Anthem Life Benefits Requested (Provide copy of Life proposal)

☐ Basic Life $_____	☐ Basic AD& D $_____	☐ Voluntary Group Term Life (VGTL) $_____
☐ Basic Life $_____	☐ Basic AD& D $_____	☐ Voluntary Group Term Life (VGTL) $_____
☐ Basic Life $_____	☐ Basic AD& D $_____	

Section 5: Anthem Life Information

Not Actively At Work Requirements for Life & Disability Products

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 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 & Disability'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 & Disability's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Employee name	Amount of insurance	Date of birth	Last date worked	Date expected to return
Reason not working	Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval
Employee name	Amount of insurance	Date of birth	Last date worked	Date expected to return
Reason not working	Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval
Employee name	Amount of insurance	Date of birth	Last date worked	Date expected to return
Reason not working	Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Section 6: Voluntary Group Life Insurance (Do not complete; Voluntary Group Life Insurance not available through ISMA)

VGTL: Mode of payment: ☐ Payroll deduction If payroll deduction, bill: ☐ 1/12 annual ☐ Special frequency ☐ Quarterly ☐ Semi-annual ☐ Annual

For VGTL: Is Accidental Death included? ☐ Yes ☐ No

Section 7: Additional Information for Quoting **Non-Medically Underwritten** Groups

(Complete this section only if group has 50+ subscribers and is providing 2 years of claims experience in lieu of medical history on enrollment applications)

Note: All ASO groups must provide experience regardless of group size.

Broker commission requested: ☐ Standard ☐ Other: _____ PEPM

Please furnish a copy of your last billing statement for medical coverage.

Please answer the following questions to the best of your knowledge for the persons eligible for medical insurance. Include proprietors, partners, employees, spouses and dependent children. Give details to questions answered "Yes" on a separate attachment.

a. Has anyone been treated for a serious illness, been hospitalized or had surgery during the past 12 months? ☐ Yes ☐ No

b. Is anyone expected to have a continuing claim for an existing mental or physical disorder? ☐ Yes ☐ No

c. Has anyone been advised during the last six months to have surgery or does anyone anticipate being hospitalized for an other reason? ☐ Yes ☐ No

d. Is there anyone who, because of illness or injury, is not actively at work or otherwise performing their normal duties on a full-time basis? Employees: ☐ Yes ☐ No; Spouses or dependents: ☐ Yes ☐ No

Groups providing experience — The following items are documented for each coverage. Check all that apply and attach supporting documentation.

	Medical	Rx Card
Rate history		
Renewal	☐	☐
Current	☐	☐
Shock losses: Over 10k diagnosis/prognosis/status		
Renewal	☐	☐
Current	☐	☐
Enrollment history		
Current	☐	☐
Previous	☐	☐
Benefit history		
Current description or booklet	☐	☐
Change/date of change	☐	☐
Enrollment by plan	☐	☐

	Medical	Rx Card
Claims experience		
Current	☐	☐
Previous	☐	☐
Premium history		
Current	☐	☐
Previous	☐	☐
Carrier history		
Current	☐	☐
Previous	☐	☐
Current enrollment		
Census (age/sex/tier/product)	☐	☐
COBRA identified	☐	☐
Retirees identified	☐	☐

Section 8: Signatures — PEO

Signatures below indicate an understanding that the Plan is being offered based upon information provided to Anthem Blue Cross and Blue Shield. Group rates quoted are valid until the renewal date and will be adjusted, if necessary, based upon the results of the Plan renewal which occurs each year. The group hereby accepts the coverage offered and authorizes Anthem Insurance Companies, Inc. to begin initial set-up.

Co-employer (group) – typed/printed	Co-employer (group) signature	Date
Not Applicable	X	Not Applicable
Administrator PEO name – typed/printed	**Administrator PEO signature**	**Date**
Not Applicable	X	Not Applicable

Section 9: Signatures — Associations and Trusts

Group name – typed/printed	Group name signature	Date
Not Applicable	X	Not Applicable
Administrator name – typed/printed	**Administrator signature**	**Date**
	X	

Fraud Notice

Any person who knowingly and with intent to defraud an insurance company, health maintenance organization or other person files an application for insurance or other form of health coverage 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.

Section 10: Signatures — Broker/Representative

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
3. I have not signed any of the applications for a group representative or individual applicant.
4. 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 re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield (Anthem) reviews and approves the application and the group receives a written notice and contract from Anthem.

Broker/Representative name	Broker/Representative signature	Date
John Enderle	X	
Writing agent name	**Writing agent signature**	**Date**
John Enderle	X	

Agency name (if applicable)
ISMA Insurance Agency

Broker/Representative street address	City	State	ZIP code
322 Canal Walk	Indianapolis	IN	46202
Writing agent street address	**City**	**State**	**ZIP code**
322 Canal Walk	Indianapolis	IN	46202

Broker/Rep ID no.	Tax ID to be paid	Broker/Rep phone no.	Anthem sales representative
8402	35-1731389	317-454-7734	Tracey Gavin

Underwriting action	Effective date	Rate band	Underwriter initials	Date

Employee Enrollment Application For 1-50 Employee Small Groups Indiana

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete in black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.* (required)
Home address — Street and PO Box if applicable			
City	County	State	ZIP code
Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Secondary phone no.	
Employee email address			
Employer name		Group no. (if known)	
Employer street address			
City		State	ZIP code

Employment status	Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week
☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired				

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other — please specify: _____
Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment
(not applicable for Life and Disability)
☐ Rehire —
Rehire date _____

☐ COBRA —
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Covered employee's Medicare entitlement
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Death

Qualifying event date:
____/____/_____
(MM/DD/YYYY)

Special Enrollment Rights for Medical Coverage Only

If you declined enrollment for yourself or your dependent(s) (including a Spouse/Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- If either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Section C: Type of Coverage

1. Medical Coverage — Select one plan option:

Enter network selected: _____

Enter product selected: _____

Enter contract code selected: _____

Member medical coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage — Please ask your employer which dental options are available before making your selection.

Anthem Dental Family and Anthem Dental Family Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime and Anthem Dental Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Member dental coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage

If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code — Please indicate the contract code for the dental plan chosen. Your employer will advise you of your plan options and contract codes. Contract code: _____

3. Vision Coverage — Select one plan option.

Member vision coverage — select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage

If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code — Please indicate the contract code for the vision plan chosen. Your employer will advise you of your plan options and contract codes. Contract code: _____

4. Life and Disability Coverage — A minimum of two employees must enroll.

☐ Basic Life and AD&D ☐ Basic Dependent Life ☐ Optional Supplemental/Voluntary Life and AD&D $ _____ (employee amount) ☐ Optional Supplemental/Voluntary Dependent Life Spouse $ _____ (spouse amount) ☐ Optional Supplemental/Voluntary Dependent Life Child $ _____ (child amount)	☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability

Current annual income: $ _____	Occupation:	Life and Disability class no.:

Primary Beneficiary — Attach a separate sheet if necessary.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

Spousal/Domestic Partner Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a Spouse's/Domestic Partner's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your Spouse/Domestic Partner if your Spouse/Domestic Partner will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your Spouse/ Domestic Partner read and sign the following. I am aware that my Spouse/Domestic Partner, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse/Domestic Partner signature	Spouse/Domestic Partner name	Date (MM/DD/YYYY)
X		

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse/domestic partner, or your children, or your spouse's/Domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Employee last name			First name	M.I.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self	
Primary Care Physician (PCP) name			PCP ID no.	Existing patient ☐ Yes ☐ No
Have you used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No				

Spouse/Domestic Partner last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No					

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____					
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No					

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____					
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No					

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate(MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____					
Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No					

*Anthem is required by the Internal Revenue Service to collect this information.

Employee name: ________________________ Social Security no.: ______/_____/________

Section E: Prior and Other Group Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name:____________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date ____________________

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

On the day your coverage begins, will you or a family member be covered by Medicare? ☐ Yes ☐ No
On the day your coverage begins, will you or a family member be covered by other health coverage? ☐ Yes ☐ No
On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following. If any coverage will remain in force once you enroll with Anthem, leave the End date blank.

Name of person covered (Last name, first, M.I.)	Type (Check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** **End:**

Section F: Waiver/Declining Coverage

Medical coverage declined for - check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for - check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for - check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
***Life/AD&D** coverage declined for: ☐ Myself
Spouse, Domestic Partner and Dependent coverage not available if life coverage is waived/declined.
Dependent Life coverage declined for: ☐ Spouse/Domestic Partner and Dependents
Short Term Disability coverage declined for: ☐ Myself
Long Term Disability coverage declined for: ☐ Myself
Optional Supplemental/Voluntary coverage declined for: ☐ Myself
Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse/Domestic Partner and Dependents
Voluntary Short Term Disability coverage declined for: ☐ Myself
Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage - check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other Insurance - Please provide company name and plan:____
- ☐ Enrolled in Individual coverage
- ☐ spouse/domestic Partner covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other — please explain: ____________________________
- ☐ No 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.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Today's date (MM/DD/YYYY)
X		

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem Blue Cross and Blue Shield (Anthem) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse/Domestic Partner, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit.
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

- I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.
- I certify each Social Security number listed on this application is correct.
- I understand that I may not assign any payment under my Anthem program. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
- I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
- I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.
- I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).
- I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

For Health Savings Account enrollees:
Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

Employee name: _____ Social Security no.: _____/_____/_____

Life and/or Disability Authorization Section — 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, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem, its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem. This information will be used for purposes which mean: 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. Anthem 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, prescription history, 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 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 further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
4. A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

This authorization, for purposes of processing this application form, is valid from the date signed for a period up to 24 months unless revoked by me in writing, which I may do at any time by contacting Anthem. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic partner unless he/she signs below. I am acting as their agent and representative.

Sign here	Applicant signature **X**	Today's date (MM/DD/YYYY)
	Spouse/Domestic Partner Signature (refer to Life and/or Disability Authorization Section to determine if this signature is required)	Today's date (MM/DD/YYYY)

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-886-6152). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-886-6152). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-886-6152). (TDD/TTY: 711)

Burmese
ဤစာရွက်စာတမ်းကို နားလည် သဘောပေါက်နိုင်ရန် အခြားဘာသာစကား တစ်မျိုးမျိုးဖြင့် သင်လိုအပ်ပါက အခကြေးငွေ ထပ်မံပေးအပ်စရာ မလိုပဲ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန ဖုန်းနံပါတ် (855-886-6152) သို့ ခေါ်ဆိုကာ တောင်းခံနိုင်ပါသည်။
(TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-886-6152)請求免費協助。(TTY/TDD: 711)

Dutch
Als u hulp nodig heeft om dit document te begrijpen in een andere taal, mag u daar zonder aanvullende kosten om vragen door te bellen met het ledenservicenummer (855-886-6152). (TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-886-6152. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-886-6152). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-886-6152) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-886-6152）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-886-6152)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Pennsylvania Dutch
Wann du Helfe brauchscht um selle Document zu verschtehe in en annere Schprooch, du kannscht fer sell frooge um nix zu bezaahle. Ruff Member Services Nummer (855-886-6152) aa. (TTY/TDD: 711)

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਬਦਲਵੀਂ ਭਾਸ਼ਾ ਵਿੱਚ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਤੁਸੀਂ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (855-886-6152) ਤੇ ਕਾਲ ਕਰਕੇ ਕਿਸੇ ਵਾਧੂ ਲਾਗਤ ਦੇ ਬਿਨਾਂ ਇਸ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-886-6152). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-886-6152). (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-886-6152). (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.