Virginia Employee Application





Anthem Life Insurance Company PO Box 182361 Columbus, OH 43218-2361 Phone 800-551-7265 Fax 614-433-8880

Read and complete all of this form. If you need more space, attach a separate sheet of paper and sign and date. Please use 4 digits for years (e.g. 2013, not 13).

EMPLOYER USE ONLY												
Group no.	Division no.			Class			Requester	d effective	date (MM/	date (MM/DD/YYYY)		
SECTION 1: REASON FOR APPLICATION	N.											
Event date (MM/DD/YYYY)	New enrollm	ent 🗆 Char	nge of clas	s \square Family	addition	☐ Change of	etatue					
Lyont date (MM/DD/1111/	☐ Late enrollm		statement	•		/address \square Ct		verage				
☐ Waive coverages (complete Sections 1, 2, 6 and 11) ☐ Portability (complete Sections 1, 2 and 7)												
COBRA - effective date:												
SECTION 2: APPLICANT INFORMATION												
Last name			First name						M.I.			
Social Security no.	Marital stat	us Single	e 🗆 Mai	ried 🗆 Div	orced	Sex	Date of bi	rth (MM/[DD/YYYY)			
	□Wido	wed 🗆 Dor	nestic par	tner	ner							
Street address	treet address			Sta	te Z	IP code	County		Municipality			
Are you actively at work? If no, sta					re you retired?		State of birth					
Employer/Group name	Occupatio	Occupation					Date of hire as full-time (MM/DD/YYYY)					
Hours worked per week for this employer Current income			: Income reported on: eek Month Year W-2 1099 0ther					Height		Weight		
Home phone no. Wo	rk phone no.		Fax no.		Email address			1				
SECTION 3: DEPENDENT DETAILS - Coi	nplete all details	for individua	ls applyin	g for this cov	erage; lis	st names of all d	ependents	5.				
Please note: If any dependent has a differ this application.	·•								neet and att	ach to		
Last name, first name, M.I.	Sex	Date of (MM/DD/		State of birt	n Socia	Social Security no.		nship	Height	Weight		
	□M □F											
	□M □F											
	□M □F											
	□M □F											
	□M □F											

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

SECTION	4: STATU	S CHANGE										
Reason fo	r change:	☐ Marriage/Domestic partner ☐ D	ivorce 🗆 Spouse de	eceased [□ Birth/ad	doption 🗆 Termin	ation of employment					
☐ Change	e name to		Date change occurred (MM/DD/YYYY)									
☐ Change	e address t	0	Date change occurred (MM	/DD/YYYY)								
□ Add/d€	elete deper	dent (name of dependent)					Date of birth/adoption (MM	/DD/YYYY)				
☐ Change	e coverage	amount	Date change occurred (MM/DD/YYYY)									
Current be	enefit amo	unt: \$										
☐ Change	e life class	to					Date change occurred (MM/DD/YYYY)					
□ Othor (change (ex						Data ahanga aggurrad (MM	/DD /VVVV)				
Utilet t	mange (ex	Jidili)					Date change occurred (MM	(וווווועעון				
SECTION	5: BENEF	ICIARY DESIGNATION										
		Name of beneficiary	Percentage	Social	Security i	no. F	Relationship to applicant	Age				
☐ Primar	у											
☐ Conting	gent											
☐ Primar												
Conting	-											
Primar												
Conting	T											
Primar												
Conting	T											
If you live named as I am awar I hereby c	in a comm a primary e that my s onsent to s	or Community Property States Only (No unity property state (AZ, CA, ID, LA, NM, No peneficiary for 50% or more of your bene spouse, the Employee/Retiree named above such designation and waive any rights I m supersedes any prior spousal consent or v	IV, TX, WA and WI), your fit amount. Please have /e, has designated som ay have to the proceed:	state may r your spous eone other t	require you e read and than me to	to obtain the signatusign the following. be the beneficiary of	ure of your spouse if your spo group life insurance under the	use will not be above policy.				
Spouse signature Spouse name (print:)			Date (MM/DD/YYYY)					
X												
SECTION	6: INSUR	ANCE COVERAGE - Check all that you	are applying for or re	ejecting. Co	verage is	limited to what is	offered by employer.					
Accept	Reject			Accept	Reject							
		Basic Life (Please complete beneficiary des	ignation in section 5)			Long Term Disability (LTD). If plan allows, include Buy-up LTD Yes No						
		Basic AD&D (Please complete beneficiary designation in section 5)				Voluntary Short Term Disability (VSTD)						
		Basic Dependent Life				Voluntary Long Term Disability (VLTD)						
		Optional Life (only available with Basic Life) x annual earnings OR \$ If plan allows, check to add one or both: Optional Employee AD&D (equal to Optional Life amount) If plan allows, check to add Optional Dependent AD&D Optional Dependent Life: Spouse \$ Child \$				Voluntary Life (complete section 5) x annual earnings OR \$ If plan allows, check to add one or both: Voluntary Employee AD&D (equal to Voluntary Life amount Voluntary Dependent Life: Spouse \$Child \$						
		Short Term Disability (STD). If plan allows, include Buy-up STD?					y AD&D (complete section 5) \$					

SECTION	7: PORTABILITY – Complete o	only if exercising po	rtability	option. Atta	act	n check with appl	lication.				
Payment mode request						Date	Date coverage with employer terminated				
Quarterly Semi-annual Annual											
Portability options: (Minimum employee coverage is \$10,000 and employee coverage is required to transfer any dependent coverage.)											
Employee											
Spouse	☐ Same ☐	Decrease to:		Delete cove	rag	e					
Children	Children 🗆 Same 🗆 Decrease to: 🗆 Delete coverage										
SECTION 8: MEDICAL AND ACTIVITIES INFORMATION											
COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person who is authorized to provide advice under an alcohol or substance abuse or weight loss program.											
Are you or any of your dependents currently pregnant? If yes, who?			☐ Yes	□No	4. Have you or any of your dependents ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Impune Deficiency Syndrome.					□No	
Expected due date:			□ 163			"NO" if you have to	ated Complex (ARC). (ested positive for HIV symptoms or the disea	but ha	ive not	∟ Yes	□ NO
Have you or any of your dependents smoked or used tobacco in the past five years?					5.		ears have you or any prescribed medication		r	□Yes	□No
Type:	If yes, who? Type:			□No	6.		rs have you or any of y n inpatient admission a		ſ	☐ Yes	□No
Quit date:(MM/DD/YYYYY) 3. In the past 10 years, have you or any of your dependents ever: a. Had high blood pressure or high cholesterol? If yes, please indicate person and last three readings in details below:			□ Yes	□No	7.	During the past the dependents sough by a medical or so any condition not	uring the past three years, have you or any of your ependents sought medical treatment, or been advised y a medical or social practitioner to seek treatment for ny condition not indicated by your answers to the receding six questions?				
b. Had heart disease, cancer, diabetes, arthritis, or asthma? c. Had counseling by a medical or social practitioner for an emotional, mental or nervous condition?			□ Yes	□ No	8.	Have you or any of your dependents ever been rated or declined for, or been refused reinstatement or renewal of, life or health insurance? If yes, name of person, date and reason:					□No
d. Been treated for substance abuse or alcohol or chemical dependency, or been convicted for driving while intoxicated?			Yes	□No		9. In the past three years, have you or any of your dependents been engaged in or contemplate during the next 12 months being engaged in sports or hobbies such as aviation, scuba diving, sky diving, or racing? If yes, please list:					□No
IMPORTAN	IT NOTICE: No person, including	an employee or agent	of Anther	m Life has th	e a	uthority to change	or omit any of these n	nedica	al questions.		
	ny "Yes" in the space below.										
Question no.	Name of individual	Name of illness or injury	Date of treatment			Remaining effects Medication and do		Name a		and address of ician/hospital	
				,							

SECTION 9: NOTICE OF EXCHANGE OF INFORMATION

Employee signature

To proposed Insured and other persons proposed to be Insured, if any — information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

SECTION 10: 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, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., 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 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 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 which mean 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 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 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 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 Life collects about me, and that I may receive a more detailed description of my rights under this law by
- 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. 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 selection(s) is hereby automatically amended to be consistent with the employer's application.
- 6. I understand that Anthem Life 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 also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. 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 rescission 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 unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.

Employee signature	Date								
X									
Spouse/Domestic partner signature	Date								
X									
SECTION 11: WAIVER OF COVERAGE									
I hereby certify that I have been given the opportunity to apply for the available group life and disability benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate in the rejected coverages noted in Section 6. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of our own accord to decline coverage. I understand that if I or any of my dependent(s) wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.									

Virginia Fraud Warning: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing any false or deceptive statement may have violated state law.

Employee name (please print)

Date