Connecticut Employee Application

Anthem Life

Anthem Life Insurance Company
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Columbus, OH 43218-2361
Phone 1-800-551-7265
Fax 1-614-433-8880

Please complete in ink. Read and complete all of this form. If you need more space, attach a separate sheet of paper and sign and date it. Please use 4 digits for years (e.g., 2016, not 16).

EMPLOYER USE ONLY

Group no.	Division no.	Class	Requested effective date (MM/DD/YYYY)

SECTION 1: REASON FOR APPLICATION

Event date: _____ (MM/DD/YYYY)

☐ New enrollment ☐ Change of status ☐ Change of beneficiary ☐ Exercise portability option (complete sections 1, 2 and 7)
☐ Change of coverage ☐ Change of class ☐ Change of name/address
☐ Waive coverages (complete sections 1, 2, 6 and 9)
☐ COBRA – effective date: _____ (MM/DD/YYYY

SECTION 2: APPLICANT INFORMATION

Last name	First name	M.I.

Social Security no.	Marital status	Sex
	☐ Single ☐ Married ☐ Divorced ☐ Widowed	☐ M ☐ F

Street address	City	State	ZIP code	County	Municipality

Are you actively at work?	If no, state reason	Are you retired?
☐ Yes ☐ No		☐ Yes ☐ No

Employer/Group name	Occupation	Date of hire as full-time (MM/DD/YYYY)

Hours worked per week for this employer	Current income: _____	Income reported on:
	☐ Hour ☐ Week ☐ Month ☐ Year	☐ W-2 ☐ 1099 ☐ Other: _____

Home phone no.	Work phone no.	Fax no.	Email address

SECTION 3: EMPLOYEE AND DEPENDENT DETAILS – Complete all details for individuals applying for this coverage; list names of all dependents.

Last name, first name, M.I.	Social Security no.	Sex	Date of birth (MM/DD/YYYY)	Age	Relationship	Height	Weight	State of birth	Eligible for federal income tax exemption	Full-time student
Employee					Self					
		☐ M ☐ F								☐ Yes ☐ No
		☐ M ☐ F								☐ Yes ☐ No
		☐ M ☐ F								☐ Yes ☐ No
		☐ M ☐ F								☐ Yes ☐ No

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: _____

Reset Form Save and Print

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: STATUS CHANGE

Reason for change: ☐ Marriage ☐ Divorce ☐ Spouse deceased ☐ Birth/adoption ☐ Termination of employment

☐ Change name to	Date change occurred (MM/DD/YYYY)
☐ Change address to	Date change occurred (MM/DD/YYYY)
☐ Change of beneficiary (complete section 5)	Date change occurred (MM/DD/YYYY)
☐ Add/delete dependent (name of dependent)	Date of birth/adoption (MM/DD/YYYY)
☐ Change coverage amount Current benefit amount: $_____ Change benefit amount to: $_____	Date change occurred (MM/DD/YYYY)
☐ Change life class to	Date change occurred (MM/DD/YYYY)
☐ Other change (explain)	Date change occurred (MM/DD/YYYY)

SECTION 5: BENEFICIARY DESIGNATION

	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

SECTION 6: INSURANCE COVERAGE — Check all that you are applying for. Coverage is limited to what is offered by employer.

☐ Basic Life
☐ Basic AD&D
☐ Dependent Life
☐ Short Term Disability
☐ Long Term Disability
☐ Other: _____
☐ Voluntary Short Term Disability (VSTD)
☐ Voluntary Long Term Disability (VLTD)
☐ Voluntary AD&D: _____ x annual earnings OR $ _____

☐ Optional Life (If checked, complete the rest of this section.)
Optional Life: _____ x annual earnings OR $ _____
Optional Life (51+ lives only): Spouse: $ _____
Child: $ _____

Payroll deduction frequency: ☐ Weekly ☐ Semi-monthly ☐ Bi-weekly ☐ Monthly

Optional AD&D: _____ x annual earnings OR $ _____

SECTION 7: PORTABILITY — Complete only if exercising portability option. Attach check with application.

Payment mode request ☐ Quarterly ☐ Semi-annual ☐ Annual	Date coverage with employer terminated

Portability options: (Minimum employee coverage is $10,000 and employee coverage is required to transfer any dependent coverage. Dependent coverage may not exceed 50% of employee coverage.))

Employee: ☐ Same ☐ Decrease to: _____ ☐ Delete coverage
Spouse: ☐ Same ☐ Decrease to: _____ ☐ Delete coverage
Children: ☐ Same ☐ Decrease to: _____ ☐ Delete coverage

SECTION 8: AUTHORIZATION — Read carefully before signing.

1. 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.
2. 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.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. 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.
5. 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 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. 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 **X**	Date
Spouse signature **X**	Date

SECTION 9: 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. 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 wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Employee signature **X**	Date
Employee name (please print)	Social Security no.

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

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal penalties.