## **Enrollment Application Instructions:**

- 1. Please type your answers on the screen for the highlighted yellow areas.
- 2. When both page 2 and 3 are completed, print your application and sign on the front in the blue highlighted area.
- 3. Return both pages to your employer.



Any questions?
Call Forrest T. Jones & Company
800-821-7303 ext 1179

## **Enrollment Application**



**Anthem** Life



Group size 2-50 eligible employees

Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and

| Missouri, Inc. u   | nderwrites HMO an ability coverages.  | d POS coverages; a     | ind ALIC underwrites   |            | ccidental                | Death       | and Dismembe     | rment, Short T                        | erm Disab             | lity and      |
|--|---|------------------------|--|------------|--------------------------|-------------|------------------|---------------------------------------|-----------------------|---------------|
| KS Residents only: Coverage applied for: ☐ PPO/Traditional (Healthy Alliance Life Insurance Company) ☐ Life & Disability (Anthem Life Insurance Company)   |   |                        |  |            |                          |             |                  |                                       |                       |               |
| Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage   |   |                        |  |            |                          |             |                  |                                       |                       | a sheets of   |
| and pre-existing   | condition limitation  | is will be reduced or  | excluded for any cor   | nditions   | listed bel               | ow. Ple     | ease note that r | no one will be                        | denied hea            | th coverage   |
|  |   | answers provided bel   |  |            |                          |             |                  | Familv □ Life                         | Only $\square$ N      | lo coverage   |
|  | NT INFORMATION  |                        | ☐ Divorced   |            | ☐ Mar                    | ried        | (·/              |                                       |                       |               |
| Relationship   | Last Name, Fir  | st Name, M.I.          | Social Security No.<br>SSN required for Lumenos.<br>Health Savings Account | Sex        | Full<br>Time<br>Student? | Age         | Date of birth    | Height/<br>Weight                     | Current tobacco user? | Disabled?     |
| Employee   |   |                        |  | □ M<br>□ F |                          |             | 1 1              | -                                     | ☐ Yes                 | ☐ Yes         |
| Spouse   |   |                        |  | □ M        |                          |             | 1 1              | /                                     | ☐ No☐ Yes             | ☐ No☐ Yes     |
| •  |   |                        |  | □ F        | □ V                      |             | 1 1              | 1                                     | □ No                  | □ No          |
| ☐ Child ☐ Other  |   |                        |  |            | ☐ Yes<br>☐ No            |             | 1 1              | 1                                     | ☐ Yes<br>☐ No         | ☐ Yes<br>☐ No |
| ☐ Child  |   |                        |  | □м         | ☐ Yes                    |             | , ,              | · · · · · · · · · · · · · · · · · · · | ☐ Yes                 | ☐ Yes         |
| Other  |   |                        |  | □F         | ☐ No                     |             | / /              | 1                                     | ☐ No                  | ☐ No          |
| ☐ Child  |   |                        |  | □ M        | ☐ Yes                    |             |                  |                                       | ☐ Yes                 | ☐ Yes         |
| Other  |   |                        |  | □ F        | □ No                     |             | / /              | 1                                     | □ No                  | ☐ No          |
| ☐ Child ☐ Other  |   |                        |  |            | ☐ Yes<br>☐ No            |             | 1 1              | 1                                     | ☐ Yes<br>☐ No         | ☐ Yes☐ No     |
|  | ─l<br>ne Address: Street.   | City, State, ZIP Cod   | l<br>de  |            |                          |             | , ,              | Co                                    | ounty                 |               |
|  |   |                        |  |            |                          |             |                  |                                       |                       |               |
| Employee Home Phone Employee Work Phone Employee Email Address   |   |                        |  |            |                          |             |                  |                                       |                       |               |
| Dependent Ho   | Dependent Home Address: Street, City, State, ZIP Code (if different from employee)  Dependent Name(s) |                        |  |            |                          |             |                  |                                       |                       |               |
| 3. MEDICAL I   | NFORMATION  | (If yes, circle cond   | dition)  |            |                          |             |                  |                                       |                       |               |
| 1. Do you or your dependents regularly take medication? Yes No 2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? Yes No 3. Are you or any of your dependents currently pregnant? due date//   |   |                        |  |            |                          |             |                  |                                       |                       |               |
| 4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor/growth; disorder of the blood or immune system; stroke, aneurysm, high blood pressure, diabetes (list age of onset below); mental/nervous disorder; Parkinson's disease; migraine/cluster headaches; seizures/epilepsy; depression; alcohol or drug abuse/dependency; kidney disease; kidney stones; liver or pancreas disorder; digestive/intestinal disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; muscular |   |                        |  |            |                          |             |                  |                                       |                       |               |
| dystrophy; infertility/reproductive organ disorder; congenital disease or birth defect; cerebral palsy? Pes No 5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? Pes No   |   |                        |  |            |                          |             |                  |                                       |                       |               |
|  | · · · · · · · · · · · · · · · · · · ·   | question. Give com     |  |            |                          |             |                  | f paper if nec                        |                       |               |
|  |   |                        |  |            |                          | Onset       | Date(s) of       | Hospitalized?                         | Surgery?              | Recovered?    |
| Quest. # Nam   | e of Individual   | Diagnosis              | Treatment  | ivieai     | cation                   | Date<br>/ / | Treatment / /    | (Y/N)                                 | (Ý/N)                 | (Y/N)         |
|  |   |                        |  |            |                          | 1 1         | 1 1              |                                       |                       |               |
|  |   |                        |  |            |                          | 1 1         | 1 1              |                                       |                       |               |
|  |   |                        |  |            |                          | 1 1         | 1 1              |                                       |                       |               |
|  |   |                        |  |            |                          | / /         | 1 1              |                                       |                       |               |
| 4. SIGNIFICA   | NT TERMS, COND  | ITIONS AND AUTHO       | ORIZATIONS (TERM   | S) Ple     | ase read                 | this se     | ection carefully | / before signi                        | ng the app            | lication.     |
| I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers in sections 1 through 3 above and in sections 5 through 10 on page 2 and 3 are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application                                      |   |                        |  |            |                          |             |                  |                                       |                       |               |
|  |   | s, benefits being deni | • ( )  |            |                          |             |                  | ION FOR EST                           | 000 00 1              | MICOLONIC     |
|  |   | AND 11 CAREFULL        |  |            | ASE KEVI                 | EW YC       | JUK APPLICAT     | ION FOR ERR                           |                       | JIVIISSIONS.  |
| Applicant Sign   |   |                        | Please Print Na  | ше         |                          |             |                  |                                       | Date /                | 1             |
| ANTHEM HISE  | ONLY  |                        |  |            |                          |             |                  |                                       |                       |               |

□ No

Pre-ex (date)

Coordination of Benefits?

☐ Yes

## **Enrollment Application**



**Anthem** Life



Group size 2-50 eligible employees

| 5. PLEASE COMPLE   | TE ALL INFOR   | MATION   |   |  |   |   |  |  |  |                                   |  |  |  |  |  |  |
|--|--|--|---|--|---|---|--|--|--|-----------------------------------|--|--|--|--|--|--|
| Reason for application:  |  |  | Group Name  |  |   |   | Group nun  | nber   | Sub Group Number                                 |                                   |  |  |  |  |  |  |
| ☐ New enrollment   |  |  |   |  |   |   |  |  |  | •                                 |  |  |  |  |  |  |
| ☐ Open enrollment (N/A for Life coverage)  |  |  | Crave Addr  |  |   |   |  |  | Canalayee  | Lline/Deleine                     |  |  |  |  |  |  |
| ☐ Qualifying event   |  |  | Group Addre   | ess  |   |   |  | Employee Hire/Rehire Date (Full time)  |  |                                   |  |  |  |  |  |  |
| (please complete d   |  |  |   |  |   |   | Date (Ful  | i uiile)   |  |                                   |  |  |  |  |  |  |
| Event Date/_   |  |  |   |  |   |   | 1  | 1  |  |                                   |  |  |  |  |  |  |
| ☐ Marriage ☐ Divorce   |  |  | Employee s  | tatus  | Hours wor   | king per Week   | Occupation   | on   | Income re  | eported by:                       |  |  |  |  |  |  |
| ☐ Birth of Child   | ☐ Adoption   |  | ☐ Active  |  |   |   | -  |  | □ W2   |                                   |  |  |  |  |  |  |
| <ul><li>☐ Termed Employment</li><li>☐ Other</li></ul>  |  | ☐ Disabled   |   | If not active  | ely working, reasor   |   |  | □ 1099   |  |                                   |  |  |  |  |  |  |
|  |  | ☐ Retired  |   |  |   |   |  | ☐ Other  | (please explain)                                 |                                   |  |  |  |  |  |  |
| ☐ COBRA  |  |  | ☐ Other (pl   | ease explain)  |   |   | -  |  |  |                                   |  |  |  |  |  |  |
| Event  | _  |  |   |  | Dunington   | Datum Data  |  |  |  |                                   |  |  |  |  |  |  |
| Date//   |  |  |   |  | Projected   | Return Date   |  |  |  |                                   |  |  |  |  |  |  |
| ☐ State Continuation   | ☐ Waiver   |  | -   |  | /   | _/  |  |  |  |                                   |  |  |  |  |  |  |
| 6. COVERAGE SELECTION (Availability dependent upon your employer's offering)   |  |  |   |  |   |   |  |  |  |                                   |  |  |  |  |  |  |
| Medical Coverage Check the medical plan  HDHP*/PPO Lumenos, Health *Do you have, or Dental Coverage: Vision Coverage:  |  |  |   |  |   |   |  |  |  |                                   |  |  |  |  |  |  |
|  | you are applying for   |  | ☐ Core  | Savings A  |   | are you establishing  | I DI   | ck one ty  | type: Please check one type:                     |                                   |  |  |  |  |  |  |
| ☐ Employee only  | ☐ PPO  |  |   | Lumenos, I   |   | a Health Savings  | Employ   | ee only  | ☐ Em   | oloyee Only                       |  |  |  |  |  |  |
| l — _ '. '   | ☐ HMO  | Г  | PPO/PPO   |  | ment Account  | •   |  | •  |  | oloyee + Spouse                   |  |  |  |  |  |  |
|  | □ POS  | _  | ☐ Core  | ☐ Lumenos.   |   | ☐ Yes ☐ No  | I — - '. '   |  |  | oloyee + child(ren)               |  |  |  |  |  |  |
|  | ☐ Hospital Sur   | gical  | ☐ Buy Up  | Incentive  |   |   | ☐ Family   | ,  | ☐ Fan  | nily Coverage                     |  |  |  |  |  |  |
|  | ☐ HDHP*  | 5  | _ , , , ,   |  |   | Savings Account   | ☐ No Cov   | /erage   | ☐ No   | coverage                          |  |  |  |  |  |  |
|  | _  |  |   |  |   | ealth Savings Account   | t  |  |  |                                   |  |  |  |  |  |  |
|  |  | Anthe  | m will facilitate th  |  |   | •   |  |  |  |                                   |  |  |  |  |  |  |
|  |  | Accou  | ınt in your name,   | if directed by yo  | our Employer.   |   |  |  |  |                                   |  |  |  |  |  |  |
| If enrolling in an HM  | O product, ple   | ase subr   | nit a PCP sel   | ection form.   | Anthem's  | PCP listings can  | be obtained  | d at ww  | w.anthem.  | com.                              |  |  |  |  |  |  |
| 7. WAIVER OF COVE  | RAGE SECTIO  | N: (Mu   | st be comple  | ted if emplo   | yee and/or  | dependents waive  | e medical, v   | vision, d  | dental or li                                     | fe coverage)                      |  |  |  |  |  |  |
| NOTE: If waiving cov   | verage, please   | complete   | this section  | . Sec  | tion 4 mus  | st also be signed a   | and dated.   |  |  |                                   |  |  |  |  |  |  |
| Medical Coverage dec   | lined for (check   | all that a   | nnly)· R  | eason for De   | clining Cove  | erage (check all tha  | at annly).   |  |  |                                   |  |  |  |  |  |  |
| •  | ,  |  | ,   |  | •   | • ,   | ,  | and ID   | Number   |                                   |  |  |  |  |  |  |
|  |  |  | برا برا ب   | •  |   |   |  | ☐ Myself ☐ Spouse ☐ Dependent(s) ☐ Covered by spouse's group coverage - Carrier name and ID Number |  |                                   |  |  |  |  |  |  |
|  | Dental Coverage declined for (check all that apply):  □ Mycelf □ Spayse □ Dependent(s)  □ Enrolled in other Insurance provided by my employer  |  |   |  |   |   |  |  |  |                                   |  |  |  |  |  |  |
|  | ☐ Myself ☐ Spouse ☐ Dependent(s)  Vision Coverage declined for (check all that apply):  — Carrier name and ID Number   |  |   |  |   |   |  |  |  |                                   |  |  |  |  |  |  |
|  |  | nt(s)  | nlv):   |  | ame and ID  | Number  |  |  |  |                                   |  |  |  |  |  |  |
| II I IVIVSEIT II Spouse  | ned for (check a   | nt(s)<br>II that ap  | ply):   |  | ame and ID  |   |  |  | er   |                                   |  |  |  |  |  |  |
| Life coverage declined   | ned for (check a<br>e  | nt(s)<br>II that ap<br>nt(s)   |   | Enrolled in  | ame and ID<br>Individual c  | Number  | ame and ID   | Numbe  | er   |                                   |  |  |  |  |  |  |
|  | ned for (check a<br>e  | nt(s)<br>II that ap<br>nt(s)   |   | Enrolled in  | ame and ID<br>Individual c  | Numberoverage - Carrier n   | ame and ID   | Numbe  | er   |                                   |  |  |  |  |  |  |
|  | ned for (check a<br>e  | nt(s)<br>II that ap<br>nt(s)   |   | Enrolled in Spouse cov Medicare  | ame and ID<br>Individual c<br>vered by em   | Numberoverage - Carrier naployer's group med  | ame and ID   | Numbe<br>ge  |  |                                   |  |  |  |  |  |  |
|  | ned for (check a<br>e  | nt(s)<br>II that ap<br>nt(s)   |   | Enrolled in Spouse cov Medicare Other (Plea  | ame and ID<br>Individual c<br>vered by em<br>se explain)  | Numberoverage - Carrier n   | ame and ID   | Numbe<br>ge  |  |                                   |  |  |  |  |  |  |
| Life coverage declined   | ned for (check a<br>e □ Depender<br>d for: □ Mysel   | nt(s)<br>Il that ap<br>nt(s)<br>f  |   | Enrolled in Spouse cov Medicare  | ame and ID<br>Individual c<br>vered by em<br>se explain)  | Numberoverage - Carrier naployer's group med  | ame and ID   | Numbe<br>ge  |  |                                   |  |  |  |  |  |  |
| Life coverage declined  8. PRIOR HEALTH IN   | ned for (check a<br>e  | nt(s) II that apnt(s) f  | DN  | Enrolled in Spouse cov Medicare Other (Plea  | ame and ID<br>Individual c<br>vered by em<br>se explain)  | Numberoverage - Carrier naployer's group med  | ame and ID   | Numbe<br>ge  |  |                                   |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co  | ned for (check a e   | nt(s) II that apnt(s) f  | DN 2 years (incl  | Enrolled in Spouse cov Medicare Other (Plea No coverag   | ame and ID<br>Individual c<br>vered by em<br>se explain)  | Numberoverage - Carrier n   | ame and ID   | Numbe  |  | Canad Data                        |  |  |  |  |  |  |
| Life coverage declined  8. PRIOR HEALTH IN   | ned for (check a e   | nt(s) II that apnt(s) f  | DN  2 years (incl Type of prior   | Enrolled in Spouse coverage Other (Plea No coverage  | ame and ID Individual covered by em use explain) e em):   | Numberoverage - Carrier naployer's group med  | ame and ID   | Numbe  |  | Cancel Date                       |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co  | ned for (check a e   | nt(s) II that apnt(s) f  | DN  2 years (incl Type of prior Employee                                    | Enrolled in Spouse coverage Other (Pleat No coverage    Muding Anther   Coverage Only  | ame and ID Individual covered by em use explain) e em):   | Numberoverage - Carrier n   | ame and ID   | Numbe  |  | Cancel Date                       |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co  | ned for (check a e   | nt(s) II that apnt(s) f  | DN  2 years (incl Type of prior Employee Employee                           | Enrolled in Spouse coverage Other (Pleat No coverage    Muding Anther   Coverage Only  | ame and ID Individual covered by em use explain) e em):   | Numberoverage - Carrier naployer's group med  | ame and ID   | Numbe  |  | Cancel Date                       |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co Insurance company na   | ned for (check as e Dependent of for: Myself of for: Myself of for: Dependent of for: Myself of  | ont(s) II that apont(s) If   | DN  2 years (incl Type of prior Employee Employee Other                     | Enrolled in Spouse coverage Other (Pleat No coverage    Muding Anther   Coverage Only  | ame and ID Individual covered by em use explain) e em):   | Numberoverage - Carrier naployer's group med  | ame and ID   | Numbe  |  | Cancel Date                       |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co Insurance company na  9. OTHER HEALTH II   | ned for (check as e Dependent of for: Myself of for | ont(s) II that apont(s) | DN  2 years (incl Type of prior Employee Employee Other                     | Enrolled in Spouse cov Medicare Other (Plea No coverage  Juding Anthe coverage Only + spouse   | ame and ID Individual covered by em see explain) ee em):  Employed Family                                 | Numberoverage - Carrier naployer's group med  | ame and ID   | Numbe<br>ge  | ective Date                                      | 1 1                               |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co Insurance company na  9. OTHER HEALTH II On the day your cove  | ned for (check as e Dependent of for: Myseld for: Myse | ont(s) II that application of the past  FORMATION  FORM | DN  2 years (incl Type of prior Employee Employee Other ON a family men     | Enrolled in Spouse cov Medicare Other (Plea No coverage Muding Anthe coverage Only + spouse  | ame and ID Individual covered by em see explain) e em):  Employee Family                                  | Numberoverage - Carrier naployer's group med e + child(ren)  Pole  Pole  Preser health insurance  | ame and ID dical Coverage  | Numbe<br>ge  | ective Date                                      | / /<br>☐ Yes ☐ No                 |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co. Insurance company na 9. OTHER HEALTH II On the day your coveramily Members Coverage Cove | ned for (check as e Dependent of for: Myseld for: Myse | ont(s) II that application of the past  FORMATION  FORM | DN  2 years (incl Type of prior Employee Employee Other ON a family men     | Enrolled in Spouse cov Medicare Other (Plea No coverage Muding Anthe coverage Only + spouse  | ame and ID Individual covered by em see explain) e em):  Employee Family                                  | Numberoverage - Carrier naployer's group med e + child(ren)  Pole  Pole  Preser health insurance  | ame and ID dical Coverage  | Numbe<br>ge  | ective Date                                      | 1 1                               |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co Insurance company na 9. OTHER HEALTH II On the day your coverage:  | ned for (check a e Depender of for: Mysel of | ont(s) II that appoint(s) If  ORMATION The past  FORMAT III you or alth Insi   | DN  2 years (incl Type of prior Employee Cher ON a family men Urance compa  | Enrolled in Spouse coverage Other (Pleated Incompanies | ame and ID Individual covered by em se explain) e mm: Employee Family red by other dress and p            | Numberoverage - Carrier naployer's group med e + child(ren)  Pole  Prince health insurance whone number Pole  Pol | ame and ID lical Covera-   | Numberge Eff   | rective Date / / Medicare? Effe                  | / /  Yes \( \) No ective date / / |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co. Insurance company na 9. OTHER HEALTH II On the day your coveramily Members Coverage Cove | ned for (check a e Depender of for: Mysel of | ont(s) II that appoint(s) If  ORMATION The past  FORMAT III you or alth Insi   | DN  2 years (incl Type of prior Employee Employee Other ON a family men     | Enrolled in Spouse coverage Other (Pleated Incompanies | ame and ID Individual covered by em se explain) e mm: Employee Family red by other dress and p            | Numberoverage - Carrier naployer's group med e + child(ren)  Pole  Pole  Preser health insurance  | ame and ID dical Covera- dicy number ecoverage a dicy number           | Numberge  Effi   | Tective Date  / /  Medicare?  Effective Date     | / /  Yes \( \) No ective date / / |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co Insurance company na  9. OTHER HEALTH II On the day your cove Family Members Cove coverage: Policy/Certificate Holde   | ned for (check as e Dependent of for: Mysel  | ont(s) Il that appoint(s) If  ORMATIO  the past  FORMAT Ill you or alth Insi   | DN  2 years (incl Type of prior Employee Other ON a family men urance compa | Enrolled in Spouse cov Medicare Other (Plea No coverage Nuding Anthe coverage Only + spouse  Inber be cove ny name, add  | ame and ID Individual covered by em se explain) e em): Employee Family red by other dress and p           | Numberoverage - Carrier naployer's group med e + child(ren)  Pol er health insurance whone number Pol Relationship to ap  | ame and ID dical Covera icy number ecoverage a icy number              | Numberge Eff   | Tective Date  / /  Medicare?  Effective Date     | / /  Yes \( \) No ective date / / |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co Insurance company na 9. OTHER HEALTH II On the day your coverage:  | ned for (check as e Dependent of for: Mysel  | ont(s) Il that appoint(s) If  ORMATIO  the past  FORMAT Ill you or alth Insi   | DN  2 years (incl Type of prior Employee Other ON a family men urance compa | Enrolled in Spouse coverage Other (Please No coverage Only [ + spouse [  Inher be coverage only [  There is no coverage only [  Ther | ame and ID Individual covered by em see explain) e em): Employee Family red by other dress and p          | Numberoverage - Carrier naployer's group med e + child(ren)  Pole + child(ren)  Relationship to apon (check all that a  | ame and ID dical Coverage icy number ecoverage a icy number oplicant   | Numberge  Effi   | Tective Date  / /  Medicare?  Effective Date     | / /  ☐ Yes ☐ No ective date / /   |  |  |  |  |  |  |
| 8. PRIOR HEALTH IN Prior Health Care Co Insurance company na  9. OTHER HEALTH II On the day your cove Family Members Cove coverage: Policy/Certificate Holde   | ned for (check as e Dependent of for: Mysel  | ont(s) Il that appoint(s) If  ORMATIO  the past  FORMAT Ill you or alth Insi   | DN  2 years (incl Type of prior Employee Other ON a family men urance compa | Enrolled in Spouse coverage Other (Pleat No coverage Only [ + spouse [  mber be coverage  only and the coverage  only [  Medicare elither   Age [  Medicare elither    Medicare elither    Age [  Indicate    Medicare elither     | ame and ID Individual covered by em see explain) e em): Employee Family red by other dress and p of birth | Numberoverage - Carrier naployer's group med e + child(ren)  Pol er health insurance whone number Pol Relationship to ap  | ame and ID dical Coverage a icy number ecoverage a icy number oplicant | Effi   | fective Date  / /  Medicare?  Effe members core: | / /  Yes \( \) No ective date / / |  |  |  |  |  |  |

## **Enrollment Application**



**Anthem** Life



Group size 2-50 eligible employees

| 10. Life and Disability Insurance  |  |   |  |   |  |  |  |  |   |  |
|--|--|---|--|---|--|--|--|--|---|--|
| ☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability  |  |   | n Disability   | Anthem By Design Short Term Disability-BUY UP   |  |  | JΡ   | Life Class   |   |  |
| ☐ Dependent Life ☐ Optional AD&D ☐ Long Term Disability  |  |   |  | ☐ Anthem By Design Long Term Disability-BUY UP  |  |  |  |  |   |  |
| ☐ Optional Life: x annual earnings OR \$   |  |   |  |   | ☐ Anthem By Design Basic Life-BUY UP   |  |  |  |   |  |
|  |  |   |  |   | omplete separ  | ate election form)   |  |  |   |  |
| Primary<br>Beneficiary   |  |   | First name, M.I.   |   |  | Social Security # Rela   |  | tionship to applicant  | Age   |  |
| Contingent<br>Beneficiary  | Contingent Last name   |   | First name, M.I.   |   |  | Social Security #  | Relat  | tionship to applicant  | Age   |  |
| 11. SIGNIFICA  | 11. SIGNIFICANT TERMS, CONDITIONS AND (UNDERWRITES LIFE AND DISABILITY COVERAGES ONLY) AUTHORIZATIONS (TERMS) Please read this section carefully before signing the application in Section 4.  |   |  |   |  |  |  |  |   |  |
| 1. I may not be be be pre-exist the certial process.  2. I understant process eligibility Compan certain process.  3. I understant pre-exclude and Life and Life and Life and Life pre-exist exclusion in the process.  3. I understant pre-exist exclusion in the process.  | ot assign any payment ield program. It ield program. It is and that completion of and enrollment criteria y (underwrites life and opersons or conditions for coverage for pre-existing insurance). It is a coverage for pre-existing exclusion approaching exclusion approaching existing exclusion approaching existing exclusion may advice, diagnosis, careful within the six-month pent. This exclusion may from the first day of day of the waiting per n does not apply to prolan within 31 days of the six of the s | this form does not guamust be satisfied (Antidisability coverages only recoverage. If accepted go conditions (Not appliance) on the appliance of the appliance | arantee acceptantem Life Insurary) may accept I, my plan may cable to MO HW andition exclusions for which commended or insas) prior to so (90 days in aiting period, frocondition who is enrolled ement for addiscreduced by wided there has so. To reduce the receive a copy prior Health | 4 ince; ince ince ince ince ince ince ince ince | If I am de my spous coverage, dependen the other employer other coverafter my of the employer addition, is adoption and my didays after. Life and of | eclining enrollment for me) because of other hear I understand that I may t(s) in this plan if I or me health insurance or groustops contribution towar erage). However, I must coverage or my dependency of I have a dependent as or placement for adoption ependent(s) provided that the marriage, birth, addisability products are ur Company, an independent | yself in the second of the sec | f or my dependensurance or ground able to enroll mependent(s) lose ealth plan coverage or ruest enrollment other coverage dependent of the other coveresult of marriage may be able to request enrollment or placement written by Anther | ent(s) (including up health plan nyself and my eligibility for rage (or if the my dependent's within 31 days ends (or after erage). In e, birth, enroll myself ent within 31 for adoption. m Life |  |
| Your health coverage will be provided by one of the following companies:   |  |   |  |   |  |  |  |  |   |  |
|  |  |   |  |   |  |  |  |  |   |  |
| Anthem Blue Cross and Blue Shield is the trade name RightCHOICE Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC). RIT, HMO Missouri, Inc., HALIC and ALIC are independent licensees of the Blue Cross and Blue Shield Association. |  |   |  |   |  |  |  |  |   |  |
| By signing Section 4, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. <i>Thank you for choosing Anthem Blue Cross and Blue Shield.</i>   |  |   |  |   |  |  |  |  |   |  |