EMPLOYEE APPLICATION

PLEASE COMPLETE IN INK. Read and complete all of this form. If you need more space, attach a separate piece if paper. Please use 4 digits for years (e.g. 1998, not 98).

Anthem Life

P.O. Box 182361
Columbus, OH 43218-2361
800-551-7265 • 614-433-8880 Fax

SECTION A. TO BE COMPLETED BY EMPLOYER/GROUP

Group Number	Division Number	Class	Requested Effective Date
AL 0000 4086	Fairfield Public Schools		

SECTION B. APPLICANT INFORMATION

REASON FOR APPLICATION: ☐ New Enrollment ☐ Change of Status ☐ Change of Beneficiary ☐ Exercise Portability Option (*complete Sections B, F & G*) ☐ Change of Coverage ☐ Change of Class ☐ Change of Name/Address ☐ Waive Life Coverages (*complete Section H*)

Social Security Number	Last Name, First Name, M.I.	Home Telephone Number ( )

Street Address	City	State/Zip	County	Municipality

Are you actively at work? ☐ Yes ☐ No *If no, state reason:* | Are you retired? ☐ Yes ☐ No | Gender: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Employer/Group Name	Occupation	Business Telephone	Fax Number	E-mail Address
Fairfield Public Schools				

Hours working per Week for this employer:	Date of hire as Full-time:	Current Income	Per: ☐ Hour ☐ Week ☐ Month ☐ Year	Income Reported on : ☐ W-2 ☐ 1099 ☐ Other _____

EMPLOYEE AND DEPENDENT DETAILS *(Complete all details for individuals applying for coverage; list names of all dependents.)*

Last Name, First Name, M.I.	Social Security Number	Sex	Date of Birth	Age	Relationship	Height	Weight	State of Birth	Eligible for federal income tax exemption?	Full-Time Student?
Employee		M F			self					
		M F								
	Not Applicable	M F								
		M F								
		M F								
		M F								

List address of all dependents if different from the applicant, including temporary address, e.g. college student.

Name/Address: Not Applicable

Name/Address: _____

Are you or any dependent currently hospitalized? ☐ Yes ☐ No *If yes, list name and reason:* _____

SECTION C. STATUS CHANGE

Reason for this change: ☐ Marriage ☐ Divorce ☐ Spouse Deceased ☐ Birth/Adoption ☐ Termination of Employment

Date Change Occurred:

☐ Change Name to:

☐ Change Address to:

☐ Change of Beneficiary *(complete section D)*

☐ Add/Delete Dependents *(include name and date of birth/adoption)*

☐ Other Change *(explain)*

☐ Change Coverage Amount:
Current Benefit Amount: $ N/A
Change Benefit Amount to: $

☐ Change Life Class to: N/A

SECTION D. BENEFICIARY DESIGNATION

	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary			- -		
Primary Beneficiary			- -		
Contingent Beneficiary			- -		
Contingent Beneficiary			- -		

SECTION E. INSURANCE COVERAGES *(Check all that you are applying for.)*

Coverage is limited to what is selected and offered by the employer.

[redacted]

☒ Long Term Disability

[redacted]

SECTION F. PORTABILITY *(Complete only if exercising portability option. Attach check with application.)*

Date Coverage with Employer terminated: | Payment Mode Requested: ☐ Quarterly ☒ Semi-Annual ☐ Annual

Coverage Transfer Options: *(Minimum employee coverage is the lesser of the amount of coverage in-force or $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 G. 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 recission 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: _____ *Date:* _____

Spouse Signature: N/A *Date:* N/A

SECTION H. WAIVER OF LIFE 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.

Print Employee Name: N/A *Social Security Number:* N/A

Employee Signature: N/A *Date:* N/A

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

In Indiana and Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Kentucky: Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance 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.