Employer Application

Group size 51+ eligible employees

Please complete in ink and use extra sheets of paper if necessary
For more information about Anthem, its products and services visit **www.anthem.com.**

Anthem use:	Group/Account #	Effective Date	State	UGT#
☐ New ☐ Termination ☐ Reclass		/ /	☐ Indiana ☐ Kentucky ☐ Ohio	

1. Effective date
Requested effective date: / /

2. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

☐ Blue Access[SM] (PPO)
☐ Blue Preferred® Primary Plus (POS)
☐ Blue Preferred® Primary (HMO)*
☐ Blue Priority[SM] (HMO)* [1]
([1]Ohio only - a health insuring corporation product or "HIC")
☐ Blue Traditional® (Indemnity)
☐ Lumenos® Health Savings Account
☐ Lumenos® Health Reimbursement Account
☐ Lumenos® Health Incentive Account
☐ Dental Traditional (Indiana and Ohio only)
☐ Dental PPO
☐ Vision
☐ Basic Life
☐ Basic AD&D
☐ Dependent Life
☐ Supplemental Life
☐ Supplemental AD&D
☐ Short Term Disability
☐ Long Term Disability

3. Medicare Part D
Prescription Drug Benefits: ☐ Wrap ☐ Waiver ☐ Subsidy

If Subsidy (CMS Information needed): Plan Sponsor ID: ____________ Application ID: ____________ Unique Benefit Option Identifier: ____________

4. Employer Information

Applicant (legal name of group)	Name of association (if applicable)
Name and title of head of firm	Name and title of administrative contact

Home office address	City	County	State	ZIP Code

eMail address	Phone number *(include area code)*	Fax number *(include area code)*
Billing address and/or contact *(if different from above)*	Tax ID / FEIN	Number of years in business

Standard industry code (SIC)	Type of business	Type of organization ☐ Partnership ☐ Labor Union ☐ Corporation ☐ Trust ☐ Sole Proprietorship ☐ Government Unit ☐ Other:

Is any part of group subject to bargaining agreement? ☐ Yes ☐ No	Union name, number, contract expiration date *(attach a copy of agreement)*	Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No

List all affiliates/subsidiaries/divisions *(list names, locations, number employed at each location.)* Attach a separate page to show any separate billing addresses, and any separate billings for life classes.

Total # of employees residing/working outside of Home Office state	List # of employees at each office location
Has your group been turned down for coverage in the last 12 months? ☐ Yes ☐ No	If yes, by whom, when and why?

Name of current health and/or life carrier(s)	Will any insurance carrier(s), in addition to Anthem, provide health coverage as part of the Group's employee benefit plan? ☐ Yes ☐ No	If yes, list carrier(s) and product(s) offered

In the past 36 months, has the company or any affiliate entity filed for protection or operated under federal / state bankruptcy laws (Chapter 11 or 7) or state receivership? ☐ Yes ☐ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity to be placed voluntarily into bankruptcy? ☐ Yes ☐ No
If Lumenos® HSA with Incentives is selected, Employer will provide the HSA plan through a cafeteria plan. Please check the box. ☐ Yes	Do you want Anthem to facilitate opening a Health Savings Account with Mellon? ☐ Yes ☐ No

Is your group subject to COBRA? ☐ Yes ☐ No	Do you have a COBRA administrator? ☐ Yes ☐ No	If no, do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No *If yes, please complete and sign the COBRA agreement.*

List employee/dependents on Continuation of Coverage / COBRA	Names of persons in COBRA eligibility period

List all totally disabled employees and dependents

5. Eligibility

Eligible full-time employees must work at least 30 (25 in OH) hours per week, must be actively at work, must have satisfied any applicable eligibility waiting period. Eligible full-time employees do not include temporary or seasonal employees.

Number of full time employees (including those within their waiting period)	Total number of employees (including part-time)	Full-time eligible enrollees as of this plan's effective date will have coverage: ☐ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on:
The day after ☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 180 days of employment *OR* First billing date after ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Do any classes of employees have a different waiting period? ☐ Yes ☐ No	If yes, explain

6. Contribution Requirements *Employer must have at least two enrolled employees enrolled in health to maintain coverage under this plan.*

Group contribution level for insurance

Health ______% Basic Life ______% Basic AD&D ______% Dependent Life ______% Supplemental Life ______% Supplemental AD&D ______% STD ______% LTD ______%

Do any classes have a percentage of group contribution different than above? ☐ Yes ☐ No	If yes, explain

7. Signature ***PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM (Read the back of this form carefully before signing)***

Signature and title of authorized group representative/title	Location where signed	Date / /
Accepted by Anthem's Underwriting Department — Signature and title		Date / /

8. Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (hereinafter "Anthem" unless otherwise specified) and to be bound by Anthem's and Anthem Life's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, Employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application.

    The employer understands that the coverage issued by Anthem may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' application or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week (25 in OH if the employer is a "small employer" as defined by Ohio law, or if employer participates in a trust to which a group policy has been issued which contains a minimum 25 hours per week eligibility requirement), must be actively at work, must have satisfied any applicable eligible waiting period.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.

Fraud Notice

KY - 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.

OH - 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.

9. Broker Certification - I hereby certify that:

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 reviews and approves the application and the group receives a written notice and contract from Anthem.

Broker name		Broker Signature	
Address			
Broker ID number	Tax ID number to be paid	Broker phone number	Date / /
Agency name *(if applicable)*		General agency broker	
Address		Anthem sales representative	

Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.
In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ® Registered marks Blue Cross and Blue Shield Association.