

Group Number : _____

Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

| | | |
|--|-----------------------|------------------------|
| Name/Address _____ _____ _____ | Date of Birth | Employee ID/SSN |
| | Division | Date of Hire |
| | | Annual Salary |
| | BillClass | SubGroup |
| | Effective Date | Gender |

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. Please complete all grayed sections. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work? Yes No
Are you retired? Yes No
Marital status: Single Married Widowed Divorced
Occupation: _____
Phone: _____
Hours per week working for this employer: _____ **Email Address:** _____

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Optional Life and AD&D Optional Life allows you to expand and enhance your benefits through convenient payroll deduction. Optional life gives you the opportunity to purchase life insurance coverage for yourself at a fraction of what insurance would cost in the individual market place. Amounts elected over \$150,000 will require an evidence of insurability form to be completed.

Accept **Decline**

You may elect \$10,000 increments to a maximum of \$300,000. Please select a benefit amount from below or select one from the attached rate matrix.

| | | | | |
|------------------------|---------------------------------------|---------------------------------------|---------------------------------------|--------------------------------|
| | Guaranteed Issue | | | Other Benefit |
| Coverage Amount | <input type="checkbox"/> \$150,000.00 | <input type="checkbox"/> \$140,000.00 | <input type="checkbox"/> \$130,000.00 | <input type="checkbox"/> _____ |
| Monthly Premium | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Reduction Schedule : By 35% at age 65; By 55% at age 70; By 70% at age 75; By 80% at age 80; By 85% at age 85. Benefits terminate at retirement.

Optional Spouse Dependent Life & AD&D

You may elect increments of \$5,000 to a maximum of \$150,000 not to exceed 50% of the employee benefit amount. You must elect Optional employee life in order to purchase the dependent coverage. Spouse/Domestic Partner amounts elected over \$25,000 will require an evidence of insurability form to be completed.

Accept Decline

You may elect \$5,000 increments to a maximum of \$150,000. You can elect one of the following benefit amounts or select another amount from the rate matrix.

| | | | | |
|------------------------|---|---|---|--------------------------------|
| | Guaranteed Issue | | | Other Benefit |
| Coverage Amount | <input type="checkbox"/> <u>\$25,000.00</u> | <input type="checkbox"/> <u>\$20,000.00</u> | <input type="checkbox"/> <u>\$15,000.00</u> | <input type="checkbox"/> _____ |
| Monthly Premium | _____ | _____ | _____ | _____ |

Spouse Coverage Terminates at employees retirement

Reduction Schedule : By 35% at age 65; By 55% at age 70; By 70% at age 75; By 80% at age 80; By 85% at age 85. Benefits terminate at retirement.

Optional Child(ren) Dependent Life & AD&D

You may elect increments of \$1,000 to a maximum of \$10,000 not to exceed 50% of the employee benefit amount. You must elect Optional employee life in order to purchase the dependent coverage.

Accept Decline

| | | | | |
|------------------------|---|--|--|--------------------------------|
| | Guaranteed Issue | | | Other Benefit |
| Coverage Amount | <input type="checkbox"/> <u>\$10,000.00</u> | <input type="checkbox"/> <u>\$9,000.00</u> | <input type="checkbox"/> <u>\$8,000.00</u> | <input type="checkbox"/> _____ |
| Monthly Premium | <u>\$1.15</u> | <u>\$1.04</u> | <u>\$0.92</u> | _____ |

*Child Coverage from birth to age 26.

BENEFICIARY DESIGNATION

It is important that your beneficiary designation is clear. It is also important that you name a primary beneficiary and contingent beneficiary. If the beneficiary is not related to you by either blood or marriage, please insert the words 'Not Related' in the relationship box.

NOTE: Please complete the section below for Employee Coverage ONLY. You "the employee" will always be considered the beneficiary for the Dependent Life Insurance when elected.

| EMPLOYEE BENEFICIARY DESIGNATION | | | | | | |
|---|-----------|------------------|-------------------|---------------------------|-----|---|
| In equal shares unless otherwise provided below | | | | | | |
| Primary Beneficiary | Last name | First name, M.I. | Social Security # | Relationship to Applicant | Age | % |
| | | | - - | | | |
| Primary Beneficiary | Last name | First name, M.I. | Social Security # | Relationship to Applicant | Age | % |
| | | | - - | | | |
| In equal shares unless otherwise provided below | | | | | | |
| Contingent Beneficiary | Last name | First name, M.I. | Social Security # | Relationship to Applicant | Age | % |
| | | | - - | | | |
| Contingent Beneficiary | Last name | First name, M.I. | Social Security # | Relationship to Applicant | Age | % |
| | | | - - | | | |

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer’s plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing 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 and subjects such person to criminal and civil penalties.

Employee Signature _____ Date _____ / _____ / _____

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Life and Disability products underwritten by Anthem Life Insurance Company an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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.