AnthemLife

Southeast, Inc.

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
	Class 1	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.

Basic Term Life and AD&D

Life Insurance replaces your income and helps your family survive after your death. This benefit is provided by your employer at no additional cost.

Accept ☒ **Decline** ☐

Coverage Amount $25,000.00

Reduction Schedule : By 35% at age 65; By 60% at age 70; By 75% at age 75. Benefits terminate at retirement.

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 $100,000 will require an evidence of insurability form to be completed.

Accept ☐ **Decline** ☐

You may elect $10,000 increments to a maximum of $300,000 or 5x salary,whichever is less. Please select a benefit amount from below or select one from the attached rate matrix

	Guaranteed Issue			Other Benefit
Coverage Amount	☐ $100,000.00	☐ $60,000.00	☐ $30,000.00	☐ _____
Semi-Monthly Premium	_____	_____	_____	_____

Reduction Schedule : By 35% at age 65; By 50% at age 70. Benefits terminate at retirement

Optional Spouse Dependent Life

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 amounts elected over $30,000 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	☐ **$30,000.00**	☐ **$20,000.00**	☐ **$10,000.00**	☐ _____
Semi-Monthly Premium	_____	_____	_____	_____

Spouse Coverage Terminates at employee's retirement

Reduction Schedule : By 35% at age 65; By 50% at age 70. Benefits terminate at retirement

Optional Child(ren) Dependent Life

You may elect $10,000 for your child(ren) **not to exceed 50% of the employee benefit amount.** You must elect Optional employee life in order to purchase the dependent coverage.

Accept ☐ **Decline** ☐

Coverage Amount **$10,000.00** **Semi-Monthly Premium** **$0.80**

*Child Coverage from 15 Days of Age to Age 26.

Short Term Disability

Short Term Disability insurance helps to replace your income if you are sick or injured and cannot work. This coverage commences on the 15th day of accident or the 15th day of sickness and is designed to continue for a period of up to 11 weeks. The plan provides income protection to replace up to 60% of your earnings to a weekly maximum of $750. This benefit is provided by your employer at no additional cost.

Accept ☒ **Decline** ☐

Weekly Benefit Amount

60% of salary to a maximum of $750

Long Term Disability

Long Term Disability allows you to purchase coverage to protect your income should you become disabled after a 90 day waiting period. You can choose to protect up to 67% of your salary to a maximum of $6,000. Your ability to earn income is your greatest asset and Long Term Disability allows you to protect your income. This benefit is provided by your employer at no additional cost.

Accept ☒ **Decline** ☐

Monthly Benefit Amount

67% of a salary to a maximum of $6,000

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.

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.

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.