VOLUNTARY GROUP LIFE ENROLLMENT FORM

Anthem Life

PART IA — PLEASE PRINT IN BLACK INK— ALL APPLICANTS MUST COMPLETE BOTH SIDES OF THIS FORM

EMPLOYEE NAME (Last, First, Middle Initial)	☐ MALE ☐ FEMALE	**SPOUSE NAME** (Last, First, Middle Initial)	☐ MALE ☐ FEMALE
HOME MAILING ADDRESS		HOME MAILING ADDRESS	
CITY / STATE / ZIP CODE		CITY / STATE / ZIP CODE	
SOCIAL SECURITY NUMBER — — / HOME PHONE NUMBER ( ) / WORK PHONE NUMBER ( )		SOCIAL SECURITY NUMBER — — / HOME PHONE NUMBER ( ) / WORK PHONE NUMBER ( )	
DATE OF BIRTH / AGE / STATE OF BIRTH / HEIGHT / WEIGHT		DATE OF BIRTH / AGE / STATE OF BIRTH / HEIGHT / WEIGHT	
EMPLOYEE COMPANY/GROUP NAME		**SPOUSE OCCUPATION/JOB TITLE**	
EMPLOYEE OCCUPATION/JOB TITLE / EMPLOYEE HIRE DATE		**NOTE: Shaded employee information in Part 1A must be completed even if not applying for coverage.**	
EARNINGS $_____ ☐ HOURLY ☐ MONTHLY ☐ ANNUALLY		If both you and your spouse or children are employees of the same employer and are applying for this coverage, each of you must complete a separate employee application.	
ARE YOU NOW ACTIVELY AT WORK? ☐ YES ☐ NO / HOURS WORKED PER WEEK (Excluding Overtime)			
EMPLOYEE TOTAL AMOUNT APPLIED FOR: $_____		**SPOUSE TOTAL AMOUNT APPLIED FOR: $_____**	
This coverage is: ☐ NEW ☐ INCREASE ☐ DECREASE In no case will coverage exceed the maximum coverage available to your group.		**This coverage is: ☐ NEW ☐ INCREASE ☐ DECREASE** Are you currently in Military Service? ☐ Yes ☐ No	
Is the spouse currently enrolled for Voluntary Group Life Coverage? ☐ Yes ☐ No		Is the employee currently enrolled for Voluntary Group Life Coverage? ☐ Yes ☐ No	
CURRENT TOBACCO USE ☐ None ☐ Cigarettes _____ Per day ☐ Chewing Tobacco ☐ Other_____ If None, have you ever smoked cigarettes? ☐ Yes ☐ No If "Yes", date last cigarette smoked _____		**CURRENT TOBACCO USE** ☐ None ☐ Cigarettes _____ Per day ☐ Chewing Tobacco ☐ Other_____ If None, have you ever smoked cigarettes? ☐ Yes ☐ No If "Yes", date last cigarette smoked _____	
BENEFICIARY NAME AND RELATIONSHIP ARE REQUIRED (Instructions on the Back)		**BENEFICIARY NAME AND RELATIONSHIP ARE REQUIRED** (Instructions on the Back)	
PRIMARY BENEFICIARY(IES) NAME / RELATIONSHIP		PRIMARY BENEFICIARY(IES) NAME / RELATIONSHIP	
SECONDARY BENEFICIARY(IES) NAME / RELATIONSHIP		SECONDARY BENEFICIARY(IES) NAME / RELATIONSHIP	

PART IB — CHILDREN'S COVERAGE

Please check one: ☐ YES ☐ NO

NOTE: If both employee & spouse are insured, children are considered dependents of the employee. Children may not be covered by both parents.

PLEASE SIGN BELOW & COMPLETE THE HEALTH STATEMENT ON THE BACK OF THIS FORM

EMPLOYEE SIGNATURE	DATE
SPOUSE SIGNATURE	DATE

It is unlawful to knowingly and intentionally provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company with regard to an application for insurance or claim for benefits. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies or other appropriate State Insurance Regulatory Agency.

HOME OFFICE USE ONLY — DO NOT WRITE BELOW THIS LINE

GROUP#	UNIT/REF	EFF. DATE	INIT/DATE		
				EE-GI: ☐ Yes $_____ **VGL** ☐ No	☐ APPR $_____ ☐ S ☐ N/S ☐ CHILD $_____ ☐ DECL ☐ EXCESS ☐ WTHDRN BY: DATE:
SPOUSE ASSIGNED #				**SPS-GI:** ☐ Yes $_____ **VGL** ☐ No	☐ APPR $_____ ☐ S ☐ N/S ☐ CHILD $_____ ☐ DECL ☐ EXCESS ☐ WTHDRN BY: DATE:

FORM NO. 96432 (REV. 1-01)

EMPLOYEE/SPOUSE – *DETACH FOR YOUR FILES*

Medical Information Bureau Notice

When we evaluate your request for insurance, the state of your health is extremely important to us. Therefore, you are requested to sign the authorization on the back of this form which allows us to collect the information necessary to process your application. Your evidence of insurability may include a paramedical examination.

Any information we obtain regarding your insurability will be treated as confidential. Anthem Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Anthem Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

PART II—HEALTH STATEMENT—ALL APPLICANTS MUST COMPLETE THIS SECTION

Name and telephone number of physician or facility which has your most recent COMPLETE PHYSICAL EXAMINATION RESULTS.

EMPLOYEE'S PHYSICIAN'S NAME:	SPOUSE'S PHYSICIAN'S NAME:
TELEPHONE NUMBER: ( )	TELEPHONE NUMBER: ( )
DATE OF LAST EXAMINATION:	DATE OF LAST EXAMINATION:

IF YOU ANSWER "YES" TO ANY OF QUESTIONS 1 THROUGH 5-B BELOW, GIVE COMPLETE DETAILS IN AREA #6

		EMPLOYEE		SPOUSE	
1. a.	Have you lost 10 or more pounds in the past twelve months? If yes, give amount and cause.	☐ YES	☐ NO	☐ YES	☐ NO
b.	Have you had an abnormal X-ray, EKG, blood test, or other diagnostic test in the past ten years?	☐ YES	☐ NO	☐ YES	☐ NO
c.	Have you ever been denied, postponed or rated up for Life or Disability insurance?	☐ YES	☐ NO	☐ YES	☐ NO
2.	Have you ever been diagnosed and/or treated by a member of the medical profession for, or had known indication of:				
a.	Heart disorder, high blood pressure, heart murmur, stroke, or chest pain?	☐ YES	☐ NO	☐ YES	☐ NO
b.	Diabetes, disorder of the digestive system, kidneys or bladder?	☐ YES	☐ NO	☐ YES	☐ NO
c.	Depression, anxiety, bi-polar disorder, disease/disorder of the nervous system, convulsions, seizures, or severe headaches?	☐ YES	☐ NO	☐ YES	☐ NO
d.	Any chronic lung disease/disorder including asthma, emphysema and tuberculosis?	☐ YES	☐ NO	☐ YES	☐ NO
e.	Any disorder of the breasts, reproductive organs, or venereal disease?	☐ YES	☐ NO	☐ YES	☐ NO
f.	Arthritis, strained or injured back, or any bone, joint or muscle disorder?	☐ YES	☐ NO	☐ YES	☐ NO
g.	Alcohol and/or Drug abuse? If yes, list drug(s):_____	☐ YES	☐ NO	☐ YES	☐ NO
h.	Cancer, tumor, leukemia, anemia, disorder of the blood or immune system?	☐ YES	☐ NO	☐ YES	☐ NO
i.	Chronic fatigue, persistent cough, recurrent lymph node enlargement, pneumonia, prolonged night sweats, or skin lesions?	☐ YES	☐ NO	☐ YES	☐ NO
3. a.	Do you have any physical or mental impairments, deformities, or ill health not covered above? If "Yes," explain in area 6 below.	☐ YES	☐ NO	☐ YES	☐ NO
b.	Are you receiving treatment or taking medication of any kind?	☐ YES	☐ NO	☐ YES	☐ NO
c.	Has surgery or treatment been advised for any existing physical, mental or emotional condition?	☐ YES	☐ NO	☐ YES	☐ NO
4. a.	Are you currently pregnant? (If "Yes," estimated due date: _____)	☐ YES	☐ NO	☐ YES	☐ NO
b.	Was your last pap smear abnormal? (If yes, give date and details below).	☐ YES	☐ NO	☐ YES	☐ NO
5.	Within the last ten years, have you been treated for or diagnosed by a member of the medical profession as having:				
a.	RESIDENTS OF ALL STATES OTHER THAN NEVADA: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other disorder of the immune system?	☐ YES	☐ NO	☐ YES	☐ NO
b.	RESIDENTS OF NEVADA: Any disease or disorder of the immune system?	☐ YES	☐ NO	☐ YES	☐ NO

6. PLEASE PROVIDE BELOW THE DETAILS TO ANY "YES" QUESTIONS ABOVE. ATTACH A SEPARATE SHEET IF NECESSARY.

QUESTION NUMBER	✔ EMPLOYEE OR SPOUSE (EE)	(SPS)	DIAGNOSIS/DESCRIPTION	DATES DIAGNOSED	LAST EPISODE	HOSPITALIZED ✔ YES	NO	TREATMENT NAME OF MEDICATION AND DOSAGE	NAME AND TELEPHONE NUMBER OF ATTENDING PHYSICIAN

NOTE: If you need to change any information given on this form, draw a line through the information, place the correct information below or next to the error, and initial the change.

I HEREBY APPLY for insurance under a group policy, either issued to or in which my employer or my spouse's employer participates, subject to all terms, conditions, and provisions of the group master policy. By my signature below, I declare that all of the statements and answers on this application (1) are true and complete to the best of my knowledge and belief, (2) are correctly and fully recorded, (3) shall constitute a part of my application, and (4) shall be relied upon and form the basis for any insurance coverage. I understand that a copy of this application form will be made available at my request.

I hereby authorize my licensed physician, medical practitioner, hospital, clinic, or other medically-related facility, insurance company, the Medical Information Bureau, or other organization or institution that has knowledge of me or my health to furnish such information to Anthem Life Insurance Company and its reinsurers. Anthem Life Insurance Company may obtain any confidential HIV-, communicable disease-, alcohol or drug abuse-, or mental health diagnosis/treatment-related information which may be protected by federal or state laws or regulations. As it pertains to alcohol and drug information, this may be revoked at any time by written notice to Anthem Life Insurance Company. Any action taken before my written revocation is received by Anthem Life Insurance Company will not be affected. I also acknowledge receipt of the Medical Information Bureau Notice. A photocopy of this authorization shall be as valid as the original, and shall remain so for two and one-half years from the date below.

EMPLOYEE: I request to be insured and authorize payroll deduction for coverage for myself and/or my spouse and dependent children. I understand that if I am not actively at work on the date coverage would otherwise become effective, no coverage will be effective until the second day following my return to work.

SPOUSE AND CHILDREN: I understand that if my spouse or child(ren) are confined in a hospital or medical care facility on the date coverage would otherwise become effective, no coverage will be effective until the day following discharge.

EMPLOYEE SIGNATURE	DATE
SPOUSE SIGNATURE	DATE

BENEFICIARY DESIGNATION

Full **GIVEN NAMES** and **RELATIONSHIP** of each beneficiary must be clearly stated. If multiple Primary and/or Secondary beneficiaries are listed, death benefits are divided equally between all the living beneficiaries, unless otherwise stated.

PRIMARY BENEFICIARY: Person or persons to receive the Life Insurance proceeds upon death of the insured.

SECONDARY BENEFICIARY: Person or persons to receive the Life Insurance proceeds when the Primary Beneficiary(ies) dies before the Insured.

MINOR CHILDREN AS BENEFICIARIES: Please be aware that if benefits are payable to a minor or a person of unsound mind, the Claim for Death Benefits must be signed and submitted by the legal conservator of such person and Letters of Conservatorship issued by the court must be furnished.

If no beneficiary is stated, benefits will be paid according to the terms of the policy.