Missouri Employee Application

AnthemLife

Anthem Life Insurance Company
PO Box 182361
Columbus, OH 43218-2361
Phone 800-551-7265
Fax 614-433-8880

Read and complete all of this form. If you need more space, attach a separate sheet of paper and sign and date. Please use 4 digits for years (e.g. 2013, not 13).

EMPLOYER USE ONLY

Group no.	Division no.	Class	Requested effective date (MM/DD/YYYY)

SECTION 1: REASON FOR APPLICATION

Event date (MM/DD/YYYY)

☐ New enrollment ☐ Change of class ☐ Family addition ☐ Change of status
☐ Late enrollment ☐ Reinstatement ☐ Change of name/address ☐ Change of coverage
☐ Waive coverages (complete Sections 1, 2, 6 and 11) ☐ Portability (complete Sections 1, 2 and 7)
☐ COBRA - effective date: _____

SECTION 2: APPLICANT INFORMATION

Last name	First name	M.I.

Social Security no.	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner	Sex ☐ M ☐ F	Date of birth (MM/DD/YYYY)

Street address	City	State	ZIP code	County	Municipality

Are you actively at work? ☐ Yes ☐ No	If no, state reason	Are you retired? ☐ Yes ☐ No	State of birth

Employer/Group name	Occupation	Date of hire as full-time (MM/DD/YYYY)

Hours worked per week for this employer	Current income: _____ ☐ Hour ☐ Week ☐ Month ☐ Year	Income reported on: ☐ W-2 ☐ 1099 ☐ Other _____	Height	Weight

Home phone no.	Work phone no.	Fax no.	Email address

SECTION 3: DEPENDENT DETAILS – Complete all details for individuals applying for this coverage; list names of all dependents.

Please note: If any dependent has a different address, please write the dependent's name, relationship to the employee, and address on a separate sheet and attach to this application.

Last name, first name, M.I.	Sex	Date of birth (MM/DD/YYYY)	State of birth	Social Security no.	Relationship	Height	Weight
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costoadicional llamando al número de servicio al cliente que se encuentra en este documento.

SECTION 4: STATUS CHANGE

Reason for change: ☐ Marriage/Domestic partner ☐ Divorce ☐ Spouse deceased ☐ Birth/adoption ☐ Termination of employment

☐ Change name to	Date change occurred (MM/DD/YYYY)
☐ Change address to	Date change occurred (MM/DD/YYYY)
☐ Add/delete dependent (name of dependent)	Date of birth/adoption (MM/DD/YYYY)
☐ Change coverage amount Current benefit amount: $_____ Change benefit amount to: $_____	Date change occurred (MM/DD/YYYY)
☐ Change life class to	Date change occurred (MM/DD/YYYY)
☐ Other change (explain)	Date change occurred (MM/DD/YYYY)

SECTION 5: BENEFICIARY DESIGNATION

	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.)

If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following.

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature **X**	Spouse name (print)	Date (MM/DD/YYYY)

SECTION 6: INSURANCE COVERAGE – Check all that you are applying for or rejecting. Coverage is limited to what is offered by employer.

Accept	Reject		Accept	Reject	
☐	☐	Basic Life (Please complete beneficiary designation in section 5)	☐	☐	Long Term Disability (LTD). If plan allows, include Buy-up LTD? ☐ Yes ☐ No
☐	☐	Basic AD&D (Please complete beneficiary designation in section 5)	☐	☐	Voluntary Short Term Disability (VSTD)
☐	☐	Basic Dependent Life	☐	☐	Voluntary Long Term Disability (VLTD)
☐	☐	Optional Life (only available with Basic Life) _____ x annual earnings OR $ _____ If plan allows, check to add one or both: ☐ Optional Employee AD&D (equal to Optional Life amount) If plan allows, check to add ☐ Optional Dependent AD&D ☐ Optional Dependent Life: Spouse $ _____Child $_____	☐	☐	Voluntary Life (complete section 5) _____ x annual earnings OR $ _____ If plan allows, check to add one or both: ☐ Voluntary Employee AD&D (equal to Voluntary Life amount) ☐ Voluntary Dependent Life: Spouse $ _____Child $_____
☐	☐	Short Term Disability (STD). If plan allows, include Buy-up STD? ☐ Yes ☐ No	☐	☐	Voluntary AD&D (complete section 5) $ _____ If plan allows, check to add: ☐ with Dependents

SECTION 7: PORTABILITY – Complete only if exercising portability option. Attach check with application.

Payment mode request

☐ Quarterly ☐ Semi-annual ☐ Annual

Date coverage with employer terminated

Portability options: (Minimum employee coverage is $10,000 and employee coverage is required to transfer any dependent coverage.)

Employee	☐ Same	☐ Decrease to: _____	☐ Delete coverage
Spouse	☐ Same	☐ Decrease to: _____	☐ Delete coverage
Children	☐ Same	☐ Decrease to: _____	☐ Delete coverage

SECTION 8: MEDICAL AND ACTIVITIES INFORMATION

COMPLETE THE FOLLOWING MEDICAL QUESTIONS FOR ALL PERSONS TO BE COVERED: For the purpose of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person who is authorized to provide advice under an alcohol or substance abuse or weight loss program.

1. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, who? _____
   Expected due date: _____

2. Have you or any of your dependents smoked or used tobacco in the past five years? ☐ Yes ☐ No
   If yes, who? _____
   Type: _____
   Quit date: _____ (MM/DD/YYYY)

3. In the past 10 years, have you or any of your dependents ever:
   a. Had high blood pressure or high cholesterol? ☐ Yes ☐ No
      If yes, please indicate person and last three readings in details below:
      _____
   b. Had heart disease, cancer, diabetes, arthritis, or asthma? ☐ Yes ☐ No
   c. Had counseling by a medical or social practitioner for an emotional, mental or nervous condition? ☐ Yes ☐ No
   d. Been treated for substance abuse or alcohol or chemical dependency, or been convicted for driving while intoxicated? ☐ Yes ☐ No

4. Have you or any of your dependents ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or tested positive for antibodies to the Human Immune Deficiency virus? ☐ Yes ☐ No

5. In the past three years have you or any of your dependents been prescribed medication? ☐ Yes ☐ No

6. In the past 10 years have you or any of your dependents had an inpatient admission and/or outpatient surgery? ☐ Yes ☐ No

7. During the past three years, have you or any of your dependents sought medical treatment, or been advised by a medical or social practitioner to seek treatment for any condition not indicated by your answers to the preceding six questions? ☐ Yes ☐ No

8. In the past three years, have you or any of your dependents been engaged in or contemplate during the next 12 months being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? If yes, please list: _____ ☐ Yes ☐ No
   _____

IMPORTANT NOTICE: No person, including an employee or agent of Anthem Life has the authority to change or omit any of these medical questions.

Explain any "Yes" in the space below. If additional space is necessary, attach a separate page including your signature and date.

Question no.	Name of individual	Name of illness or injury	Date of treatment	Remaining effects	Medication and dosage	Name and address of physician/hospital

SECTION 9: NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.**

SECTION 10: AUTHORIZATION – Read carefully before signing.

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. 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.
4. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
5. 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.
6. 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 also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. 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 rescission 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 unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic partner unless he/she signs below. I am acting as their agent and representative. ***Incomplete applications will be mailed back to you for completion.***

This may delay the effective date of your coverage.

Employee signature **X**	Date
Spouse/Domestic partner signature **X**	Date

SECTION 11: WAIVER OF COVERAGE

I hereby certify that I have been given the opportunity to apply for the available group life and disability benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate in the rejected coverages noted in Section 6. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of our own accord to decline coverage. I understand that if I or any of my dependent(s) wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Employee signature **X**	Employee name (please print)	Date

Fraud Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. 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 Missouri division of insurance within the department of regulatory agencies.

Reset Form Save and Print