Insurance ISMA Agency

322 Canal Walk • Indianapolis, IN 46202-3268

(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

To request a quote, please complete and return the following:

(1) **Authorization** for ISMA Insurance Agency to obtain quote for ISMA-sponsored Anthem and/or Anthem Small Group Plan;

(2) **Anthem Group Enrollment Form** – Required information highlighted in blue;

(3) **One Anthem Enrollment Application for every employee working at least 30 hours per week** – employees *applying for coverage* complete Sections 1, 2 (New enrollment), 4-11; employees *waiving coverage* complete Sections 1, 2 (Waiver), 5-7, 12.

When all forms are completed, scan and email them to ismaia@ismanet.org, or fax them our private fax line, (317) 261-2238.

Upon receipt, we will review the forms to be sure they are complete, and follow up to collect any missing information. We will then forward them to Anthem Underwriting for review and rating. Finally, we will email firm rates for each plan option for your consideration.

If you have any questions, please email the ISMA Insurance Team at ismaia@ismanet.org or call (317) 261-2060 and say you're calling with questions about ISMA-sponsored Anthem group health insurance.

Authorization for ISMA Insurance Agency
to obtain quote for
ISMA-sponsored Anthem and/or Anthem Small Group Plan

I authorize ISMA Insurance Agency to obtain a quote for ISMA-sponsored Anthem group health insurance or an Anthem Small Group plan for:

Employer Name

Signature of Authorized Signer Date

Name of Authorized Signer

Associations, Trusts and PEOs Group Enrollment Form

Association/Trust/PEO name

Client ID no. (if applicable)

To obtain a proposal:

All groups should complete all **highlighted fields**. Provide additional information based on the underwriting category.

Medically Underwritten Groups:

- Complete required fields on the front of this form.
- Employees must complete ***Section 3: Medical/Information*** of the Enrollment Application.

Non-Medically Underwritten Groups:

- Complete required fields on the front of this form.
- Employees applications are **not** required with a request for proposal. All parts of the Employee Application excluding ***Section 3: Medical/Information*** must be completed with a sold case submission.
- Provide additional information in section 4 on the back of this form.

Section 1: Group Information

Group name			Number of years in business	Medically underwritten ☐ Yes ☐ No
Street address		City	State	ZIP code
Effective date	SIC code	Primary group contact name	Phone no.	Fax no.
Group tax ID no.	Email address			

Section 2: Eligibility

Employees are eligible for health insurance if they work a **minimum of 30 hours per week.**
Important: Every employee working the minimum hours/week must complete an application; those waiving coverage should sign the waiver at end of form.

1. Total number of employees working minimum hours/week ______
2. Number of employees waiving coverage due to spousal coverage ______
3. Subtract number 2 from number 1 — Number 1 – number 2 = ______ = Number of eligible employees
4. Number of employees waiving coverage and not covered by spouse ______
5. Subtract number 4 from number 3 — Number 3 – number 4 = ______ = Number of employees enrolling
6. Divide number 5 by number 1. — Number 5 ÷ number 1 = ______
   This result must be at least 50% otherwise the group is not eligible for coverage under the plan.
7. Divide number 5 by number 3. — Number 5 ÷ number 3 = ______
   This result must be at least 75% otherwise the group is not eligible for coverage under the plan.

The following documents are required with the submission of the confirmed *Group Enrollment Form*:

- Group's Census
- A copy of the prior carrier's premium billing
- Completed employee enrollment forms

Will Life AD&D be offered to those not enrolling in the medical? ☐ Yes ☐ No

Employer contribution – If employer pays 100% of premium all eligible employees must enroll.
Medical: ________ % Employee ________% Dependents Life AD&D: ________ % Employee

Probationary period for new employees
The day after: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days
First billing date after: ☐ 0 days ☐ 30 days ☐ 60 days

Return from leave or layoff
Employees returning from a leave of absence or lay off within 63 days will be made effective on the first day of the month following rehire. If more than 63 days has elapsed between date of termination of the group coverage and the rehire date, the probationary or service waiting period will apply.

Employee terminations – Coverage will be terminated:
☐ Last day of the month ☐ Last day worked

Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company are independent licensees 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.

Section 3: Benefits Requested

Medical				
Plan 1: ______ Plan 2: ______				
Dental	Voluntary	Ortho	Stand-alone	Mixed enrollment
Plan 1: ______	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 2: ______	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 3: ______	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vision		Voluntary	Stand-alone	Mixed enrollment
Plan 1: ______		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Plan 2: ______		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section 4: Anthem Life Benefits Requested (Provide copy of Life proposal)

☐ Basic Life $______ ☐ Basic AD& D $______ ☐ Voluntary Group Term Life (VGTL) $______

☐ Basic Life $______ ☐ Basic AD& D $______ ☐ Voluntary Group Term Life (VGTL) $______

☐ Basic Life $______ ☐ Basic AD& D $______

Section 5: Anthem Life Information

Not Actively At Work Requirements for Life & Disability Products

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Anthem Life & Disability may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied.

1. The employee's absence must be due to illness or injury.
2. The employee must be covered by the prior carrier on the day immediately prior to Anthem Life & Disability's effective date of coverage for your group.
3. The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at-work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Anthem Life & Disability's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Employee name	Amount of insurance	Date of birth	Last date worked	Date expected to return
Reason not working	Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval
Employee name	Amount of insurance	Date of birth	Last date worked	Date expected to return
Reason not working	Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval
Employee name	Amount of insurance	Date of birth	Last date worked	Date expected to return
Reason not working	Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Section 6: Voluntary Group Life Insurance (Do not complete; Voluntary group life insurance not available through ISMA)

VGTL: Mode of payment: ☐ Payroll deduction If payroll deduction, bill: ☐ 1/12 annual ☐ Special frequency
☐ Quarterly ☐ Semi-annual ☐ Annual

For VGTL: Is Accidental Death included? ☐ Yes ☐ No

Section 7: Additional Information for Quoting **Non-Medically Underwritten** Groups (Complete this section only if group has 50+ subscribers and is providing 2 years of claims experience in lieu of medical history on enrollment applications)

Note: All ASO groups must provide experience regardless of group size.

Broker commission requested: ☐ Standard ☐ Other: ___________ PEPM

Please furnish a copy of your last billing statement for medical coverage.

Please answer the following questions to the best of your knowledge for the persons eligible for medical insurance. Include proprietors, partners, employees, spouses and dependent children. Give details to questions answered "Yes" on a separate attachment.

a. Has anyone been treated for a serious illness, been hospitalized or had surgery during the past 12 months? ☐ Yes ☐ No

b. Is anyone expected to have a continuing claim for an existing mental or physical disorder? ☐ Yes ☐ No

c. Has anyone been advised during the last six months to have surgery or does anyone anticipate being hospitalized for an other reason? ☐ Yes ☐ No

d. Is there anyone who, because of illness or injury, is not actively at work or otherwise performing their normal duties on a full-time basis? Employees: ☐ Yes ☐ No Spouses or dependents: ☐ Yes ☐ No

Groups providing experience – The following items are documented for each coverage. Check all that apply and attach supporting documentation.

		Medical	Rx Card
Rate history			
	Renewal	☐	☐
	Current	☐	☐
Shock losses: Over 10k diagnosis/prognosis/status			
	Renewal	☐	☐
	Current	☐	☐
Enrollment history			
	Current	☐	☐
	Previous	☐	☐
Benefit history			
	Current description or booklet	☐	☐
	Change/date of change	☐	☐
	Enrollment by plan	☐	☐

		Medical	Rx Card
Claims experience			
	Current	☐	☐
	Previous	☐	☐
Premium history			
	Current	☐	☐
	Previous	☐	☐
Carrier history			
	Current	☐	☐
	Previous	☐	☐
Current enrollment			
	Census (age/sex/tier/product)	☐	☐
	COBRA identified	☐	☐
	Retirees identified	☐	☐

Section 8: Signatures – PEO (Do not complete this section; complete Section 9 instead)

Signatures below indicate an understanding that the Plan is being offered based upon information provided to Anthem Blue Cross and Blue Shield. Group rates quoted are valid until the renewal date and will be adjusted, if necessary, based upon the results of the Plan renewal which occurs each year. The group hereby accepts the coverage offered and authorizes Anthem Insurance Companies, Inc. to begin initial set-up.

Co-employer (group) – typed/printed	Co-employer (group) signature X	Date
Administrator PEO name – typed/printed	Administrator PEO signature X	Date

Section 9: Signatures – Associations and Trusts

Group name – typed/printed	Group name signature X	Date
Administrator name – typed/printed	Administrator signature X	Date

Fraud Notice

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.

Section 10: Signatures — Broker/Representative (This section to be completed by writing agent)

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

Broker/Representative name	Broker/Representative signature X *Tom Martens*	Date
Writing agent name	Writing agent signature X *Donna Mallinckrodt*	Date

Agency name (if applicable)

Broker/Representative street address	City	State	ZIP code
Writing agent street address	City	State	ZIP code

Broker/Rep ID no.	Tax ID to be paid	Broker/Rep phone no.	Anthem sales representative

Underwriting action	Effective date	Rate band	Underwriter initials	Date

Enrollment Application

Group

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
To search for *Blue Access℠ PPO Providers,* visit www.anthem.com

1. Employer/Group use: Employer Name and Address:							
Anthem use: Group #	Sub-group # / Life Division #	Request. Effective Date	Life Classification ☐ Yes ☐ No	Record #			
		/ /	Life Class	ME #			
Plan	**ISMA use:** Agent	Health Effective Date	Life Effective Date	Dental Effective Date	Waiting Period	COB	Pre-ex (date)
		/ /	/ /	/ /		☐ Yes ☐ No	/ /

2. Reason for Application

☐ New enrollment ☐ New hire
☐ Waiver ☐ Rehire (date) ___/___/___
☐ Annual open enrollment (N/A to life) ☐ Add dependent (see section 3)
☐ COBRA
Qualifying event ________ Event date ___/___/___

3. Status Change/Event

Event date ___/___/___
☐ Marriage ☐ Adoption*
☐ Birth ☐ Legal Guardianship*
☐ Other ________
Include legal documentation.

4. Type of Coverage/Plan

Health Coverage		***Dental Coverage***	***Life Coverage***
☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage	Medical Plan Name ________	☐ Yes ☐ No	☐ Yes ☐ No

5. Employee Information

Last name	First name, M.I.	Date of birth / /	Age	Sex ☐ M ☐ F	Social security # – –	☐ Single ☐ Divorced ☐ Married	Height	Weight

Home address	City	State	ZIP code	County (KY residents include Municipality)

Home telephone ( ) –	Business telephone ( ) –	eMail Address

Are you: Retired? ☐ Yes ☐ No · Disabled? ☐ Yes ☐ No · Hospitalized? ☐ Yes ☐ No	Occupation	Full time hire date / /	Hours working per week	Income reported by: ☐ W2 ☐ 1099 ☐ Other: ________

6. Family Information ***Spouse and dependents to be covered. (Attach a separate sheet if necessary.)***

1 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ________	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

2 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ________	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

3 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ________	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

4 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other ________	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

7. Life and Disability Insurance **Please complete Primary and Contingent Beneficiary Information in its entirety.*

☐ Basic Life ☐ Basic AD&D
☐ Current Income: $ ________ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*

Are you currently actively at work? ☐ Yes ☐ No
If no, reason:

	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary			– –		
Contingent Beneficiary			– –		

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8. Other Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number		Effective date / /
Policy/certificate holder's name	Social Security number – –	Date of birth / /	Relationship to applicant	

If you and/or your dependents are enrolled in Medicare Part A or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
		/ /	/ /	/ /
		/ /	/ /	/ /

Reason for Medicare enrollment:
☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

9. Prior Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #:	Group name/ID #	Dates policy in effect: / / — / /
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No	List prior carrier(s)	Dates policy in effect: / / — / /

Please check the type of prior coverage
☐ Employee ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Employee / Spouse / Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

10. Medical Information ***Group size 2-19, eligible employees complete in full. Group size 20-50, eligible employees complete questions 1-5. Group size 51+, skip this section.***

Please note that no person will be denied health coverage on an individual basis due to the answers provided below, except for Medicare Carve-Out.

(If yes, circle condition)

1. Do you or your dependents regularly take medication?............................ ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future?..................... ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant?.......................... ☐ Yes ☐ No

   If yes, name ____________________ due date ___/___/___
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes **(list age of onset below);** mental/nervous disorder, depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy?.. ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV?... ☐ Yes ☐ No
6. Have you or any of your dependents visited the emergency room on 2 or more occurrences for the same condition in the last 12 months?.......... ☐ Yes ☐ No
7. Have you or your dependents used tobacco products in the last 12 months?... ☐ Yes ☐ No

(If yes, circle condition)

8. To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis of or treatment for the following:
   a. Ulcer, hernia, diverticulitis, irritable bowel or other intestinal disorder? ...... ☐ Yes ☐ No
   b. Thyroid, goiter or gallbladder disorder? .... ☐ Yes ☐ No
   c. High blood pressure, cholesterol or triglycerides? .... ☐ Yes ☐ No
   d. Anemia, chest pain, heart murmur or disorder of the veins/circulatory system?...... ☐ Yes ☐ No
   e. Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints? ...... ☐ Yes ☐ No
   f. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system? ... ☐ Yes ☐ No
   g. Asthma, allergies, sinus, or disorder of the respiratory system? .... ☐ Yes ☐ No
   h. Any STD or disorder of the prostate, genital, reproductive or urinary system?..... ☐ Yes ☐ No
   i. Any disorder of the skin, ears, or eyes? .... ☐ Yes ☐ No
9. Have you or any of your dependents, within the last 2 years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated? .... ☐ Yes ☐ No
10. Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years? .... ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)	Physician's name
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				

Please read the TERMS on the reverse side of this page. Your Signature is required on the reverse side of this to submit this application.

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Significant terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or 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.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. 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 Anthem 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 recission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

11. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.
By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature	Date / /

12. PLEASE READ: If you are declining coverage for yourself, spouse, or dependents, you must complete and list all below, and sign and date application.

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply

☐ I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

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

Applicant signature	Date / /