Employer Application

Group size 2-50 eligible employees

Please complete in ink and use extra sheets of paper if necessary.
For more information about Anthem, its products and services visit **www.anthem.com.**

Anthem use:	Group/Account #	Effective Date	State	UGT#
☐ New ☐ Termination ☐ Reclass		/ /	☐ Indiana ☐ Kentucky ☐ Ohio	

1. Effective date

Requested effective date: / /

2. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

☐ Blue Access℠ (PPO)
☐ Blue Preferred® Primary Plus (POS)
☐ Blue Preferred® Primary (HMO)*
☐ Blue Priority℠ (HMO)* [1]
([1]Ohio only - a health insuring corporation product or "HIC")

☐ Blue Traditional® (Indemnity)
☐ Dental Traditional (Indiana and Ohio only)
☐ Dental PPO
☐ Vision

☐ Basic Life
☐ Basic AD&D
☐ Dependent Life

☐ Supplemental Life
☐ Supplemental AD&D
☐ Short Term Disability
☐ Long Term Disability

3. Employer Information

Applicant (legal name of group)	Name of association (if applicable)
Name and title of head of firm	Name and title of administrative contact

Home office address	City	County	State	ZIP Code

eMail address	Phone number *(include area code)*	Fax number *(include area code)*
Billing address and/or contact *(if different from above)*	Tax ID/FEIN	Number of years in business

Standard industry code (SIC)	Type of business

Is any part of group subject to bargaining agreement? ☐ Yes ☐ No	Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No	Total # of employees residing/working outside of Home Office state

List all affiliates/subsidiaries/divisions *(list names, locations, number employed at each location.)* Attach a separate page to show any separate billing addresses, and any separate billings for life classes.

Name of current health and/or life carrier(s)	Next renewal date / /

Is your group subject to COBRA? ☐ Yes ☐ No	Do you have a COBRA administrator? ☐ Yes ☐ No	If no, do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No *If yes, please complete and sign the COBRA agreement.*

List employees/dependents on Continuation of Coverage/COBRA	Names of persons in COBRA eligibility period

4. Eligibility

Eligible full-time employees must work at least 30 (25 in OH) hours per week, must be actively at work, must have satisfied any applicable eligibility waiting period.
Eligible full-time employees do not include temporary or seasonal employees.

Number of full time employees (including those within their waiting period)	Total number of employees (including part-time)	Total number of employees not actively at work	Full-time eligible enrollees as of this plan's effective date will have coverage: ☐ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on:
(IN/KY) the day after ☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 180 days of employment *or the first billing date after* ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days or ☐ 180 days of employment
(OH) after ☐ 0 days ☐ 30 days ☐ 60 days or on the ☐ 91st day of employment

Do any classes have a different waiting period? ☐ Yes ☐ No	If yes, explain

5. Contribution and Minimum Participation Requirements *Employer must have at least two enrolled employees enrolled in health to maintain coverage under this plan.*

Group contribution level for health: 50% of the single fee premium; at least 25% of total premium. For life, AD&D, STD, LTD: at least 25% of premium for each coverage except dependent life. If group contribution is 100%, 100% participation is required. Group minimum participation for Health: the greater of 75% of "Net Eligible Employees" or 50% of all eligible employees. "Net Eligible Employees" is the total number of eligible employees less those employees with other group health coverage through a spouse or as part of a collectively bargained or union plan.

Group contribution level for insurance

Health_______% Basic Life_______% Basic AD&D_______% Dependent Life_______% Supplemental Life_______% Supplemental AD&D_______% STD_______% LTD_______%

Do any classes have a percentage of group contribution different than above? ☐ Yes ☐ No	If yes, explain:

6. Signature ***PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM (Read the back of this form carefully before signing)***

Signature and title of authorized group representative	Location where signed	Date / /
Accepted by Anthem's Underwriting Department – Signature and title		Date / /

7. Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (hereinafter "Anthem" unless otherwise specified) and to be bound by Anthem's and Anthem Life's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, Employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
14. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work 30 (if employer is located in Kentucky/Indiana), 25 (if employer is located in Ohio) or more hours per week (unless otherwise approved by Anthem in writing), and meet any other eligibility requirements for coverage; employer meets the definition of small employer under applicable law of the state where it is domiciled, which is: KY - An employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. OH - An employer who employed an average of at least two but no more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. All persons treated as a single employer under the US IRC of 1986 as amended, shall be considered an employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. IN - any person, firm, corporation, limited liability company, partnership or association actively engaged in business, who, on at least 50% of the working days of the employer during the preceding calendar year employed at least two but not more than 50 eligible full time employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer. A plan is subject to IN small group laws if either of the following conditions is met: (1) any part of the premium or benefits is paid by employer, or any covered individual is reimbursed, through wage adjustments or otherwise, by employer for any part of the premium (not including administrative expenses of administering a payroll deduction plan where employee contributes 100% of the premium without reimbursement); or (2) the employer treats the plan as part of a plan or program for purposes of the United States Internal Revenue Code of 1986, as amended.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.

Fraud Notice

KY - 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.

OH - 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.

8. Broker Certification – I hereby certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I am not aware of any health history of any applicant that does not appear on the application.
3. 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.
4. I have not signed any of the applications for a group representative or individual applicant.
5. I have advised the group that 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 reviews and approves the application and the group receives a written notice and contract from Anthem.

Broker name		Broker Signature	
Address			
Broker ID number	Tax ID number to be paid	Broker phone number	Date / /
Agency name *(if applicable)*		General agency broker	
Address		Anthem sales representative	

Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.
In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ® Registered marks Blue Cross and Blue Shield Association.