Application For Group Insurance - CHEIBA Trust

Anthem Life

FORM MUST BE FILLED OUT IN BLACK BALLPOINT OR TYPEWRITER — PLEASE PRINT AND PRESS FIRMLY

EMPLOYED BY

COVERAGES APPLYING FOR (If Applicable)
☐ Life
☐ AD&D
☐ Dependent Life
☐ Short Term Disability
☐ Long Term Disability
☐ Supplemental Life Amount ____________

APPLICANT NAME (Last, First, Initial)

PAYROLL NUMBER (IF APPLICABLE)

ADDRESS (Street, City, State, Zip Code)

SOCIAL SECURITY NUMBER

SEX ☐ Male ☐ Female

DATE OF EMPLOYMENT (Month, Day, Year)

DATE OF BIRTH (Month, Day, Year)

EARNINGS
$ ___________________
☐ HOURLY ☐ MONTHLY
☐ WEEKLY ☐ SEMIMONTHLY
☐ BIWEEKLY ☐ YEARLY

HOURS WORKED PER WEEK EXCLUDING OVERTIME

JOB TITLE

DEPARTMENT

PRIMARY BENEFICIARY NAME (If married woman, give first, married and maiden name) | BIRTHDATE (Mo., Day, Yr.) | RELATIONSHIP

SECONDARY BENEFICIARY NAME (If married woman, give first, married and maiden name) | BIRTHDATE (Mo., Day, Yr.) | RELATIONSHIP

I hereby apply for the insurance for which I am or may become eligible under the Group Policy or Policies issued to my Employer named above by the Anthem Life Insurance Company and hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance. This authorization may be revoked by me at any time by written notice to my Employer.

I certify that I am a full-time employee of the employer named above and am compensated by salary or wages. I understand that if I am not actively at work on the date my insurance would otherwise become effective, the insurance will not become effective until the second successive day I am actively at work thereafter.

HOME OFFICE USE ONLY

GROUP NUMBER

BILLING UNIT NUMBER

REFERENCE NUMBER (IF APPLICABLE)

CLASS NUMBER

G.I. CODE

UNDERWRITING REASON
☐ Small Group
☐ Late Enrollee
☐ ______ % Employer Paid
☐ Excess
Amount ____________

UNDERWRITING ACTION
☐ Approved
☐ Declined
Initials __________
Date ___________

EFFECTIVE DATE

	YES	NO
Life/AD&D	☐	☐
Amount ________________________		
Supplemental	☐	☐
Amount ________________________		
Dependent Life	☐	☐
Amount ________________________		
STD	☐	☐
Amount ________________________		
LTD	☐	☐
Amount ________________________		

LTD Effective Date ________________________

PROCESS DATE ________________ INITIALS ______________

☐ SH ☐ EP

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

DATE SIGNED | APPLICANT SIGNATURE

WAIVER OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the benefits of my Employer's Group Insurance Plan underwritten by Anthem Life Insurance Company. The Plan has been explained to me and I decline to participate.

It is understood and agreed that by the completion of this waiver of insurance form I forfeit my rights to coverage under the Group Policy, and should I elect at a later date to participate in the plan, I must furnish at my own expense, evidence of insurability satisfactory to Anthem Life Insurance Company.

DATE SIGNED | EMPLOYEE SIGNATURE

EMPLOYEE (PRINTED) NAME | EMPLOYER NAME