

**VOLUNTARY GROUP LIFE
ENROLLMENT FORM**

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

EMPLOYEE NAME (Last, First, Middle Initial)				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		SPOUSE NAME (Last, First, Middle Initial)				<input type="checkbox"/> MALE <input type="checkbox"/> 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		DATE OF BIRTH		AGE		STATE OF BIRTH	
				HEIGHT						HEIGHT	
				WEIGHT						WEIGHT	
EMPLOYEE COMPANY/GROUP NAME						SPOUSE OCCUPATION/JOB TITLE					
EMPLOYEE OCCUPATION/JOB TITLE						EMPLOYEE HIRE DATE					
EARNINGS \$ <input type="checkbox"/> HOURLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY						NOTE: Shaded employee information in Part 1A must be completed even if not applying for coverage.					
ARE YOU NOW ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO						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.					
HOURS WORKED PER WEEK (Excluding Overtime)											
EMPLOYEE TOTAL AMOUNT APPLIED FOR: \$ This coverage is: <input type="checkbox"/> NEW <input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE Coverage amounts in excess of \$150,000 may not exceed five (5) times your basic annual earnings. In no case will coverage exceed the maximum coverage available to your group.						SPOUSE TOTAL AMOUNT APPLIED FOR: \$ This coverage is: <input type="checkbox"/> NEW <input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE If employee applies and is approved for this coverage, spouse coverage may not exceed the employee's approved coverage amount. If the employee does not apply or is not approved for coverage, spouse coverage may not exceed \$100,000.					
Is the spouse currently enrolled for Voluntary Group Life Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No						Is the employee currently enrolled for Voluntary Group Life Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you used tobacco and/or nicotine in any form within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," date last used _____						Have you used tobacco and/or nicotine in any form within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," date last used _____					
BENEFICIARY NAME AND RELATIONSHIP ARE REQUIRED						BENEFICIARY NAME AND RELATIONSHIP ARE REQUIRED					
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: \$2,500 \$5,000 \$7,500 \$10,000 NONE

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

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.

HOME OFFICE USE ONLY — DO NOT WRITE BELOW THIS LINE									
GROUP#	UNIT/REF	EFF. DATE	INIT/DATE	EE-GI: <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No	VGL <input type="checkbox"/> No	APPR \$ _____	S	CHILD	\$ _____
						DECL <input type="checkbox"/> WITHDRAWN <input type="checkbox"/> N/S		BY: DATE:	
						APPR \$ _____		\$ _____	
						DECL <input type="checkbox"/> WITHDRAWN <input type="checkbox"/> N/S		BY: DATE:	

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. | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b. Have you had an <u>abnormal</u> X-ray, EKG, blood test, or other diagnostic test in the past ten years? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| c. Have you ever been denied, postponed or rated up for Life or Disability insurance? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> 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? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b. Diabetes, disorder of the digestive system, kidneys or bladder? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| c. Depression, anxiety, bi-polar disorder, disease/disorder of the nervous system, convulsions, seizures, or severe headaches? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| d. Any chronic lung disease/disorder including asthma, emphysema and tuberculosis? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| e. Any disorder of the breasts, reproductive organs, or venereal disease? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| f. Arthritis, strained or injured back, or any bone, joint or muscle disorder? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| g. Alcohol and/or Drug abuse? If yes, list drug(s): _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| h. Cancer, tumor, leukemia, anemia, disorder of the blood or immune system? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| i. Chronic fatigue, persistent cough, recurrent lymph node enlargement, pneumonia, prolonged night sweats, or skin lesions? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. a. Do you have any physical or mental impairments, deformities, or ill health not covered above? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b. Are you receiving treatment or taking medication of any kind? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| c. Has surgery or treatment been advised for any existing physical, mental or emotional condition? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. a. Are you currently pregnant? (If "Yes," estimated due date: _____) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b. Was your last pap smear abnormal? (If yes, give date and details below). | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> 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? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b. RESIDENTS OF NEVADA: Any disease or disorder of the immune system? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> 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		HOSPITALIZED		TREATMENT NAME OF MEDICATION AND DOSAGE	NAME AND TELEPHONE NUMBER OF ATTENDING PHYSICIAN
				DIAGNOSED	LAST EPISODE	YES	NO		

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 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) is 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