Employee Application — New York

For Group Term Life, Accidental Death and Dismemberment, Short-Term Disability and Long-Term Disability Insurance

INSTRUCTIONS:
PLEASE COMPLETE IN INK. Read and complete all of this form. If you need more space, attach a separate piece of paper. Please use 4 digits for years (e.g. 2014, not 14).

Anthem Life & Disability Insurance Company

AnthemLife

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

SECTION 1: EMPLOYER/GROUP INFORMATION — To be completed by employer

Group no.	Group name	Class	Requested effective date
	Monticello Teachers Assoc. Benefit Trust		

SECTION 2: APPLICANT INFORMATION

Reason for application ☐ New enrollment ☐ Change of status ☐ Change of beneficiary ☐ Change of coverages ☐ Reinstatement ☐ Late enrollment ☐ Change of class ☐ Change of name/address

Last name	First name		Social Security no.		Phone no.
Street address	City	State	ZIP code	County	Municipality

Are you actively at work? ☐ Yes ☐ No If no, state reason: _____	Are you retired? ☐ Yes ☐ No	Gender ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer/Group name	Occupation	Business no.	Fax no.	Email address

Hours working per week for this employer: _____	Date of hire as Full-time	Current income	Per: ☐ Hour ☐ Week ☐ Month ☐ Year	Income reported on: ☐ W-2 ☐ 1099 ☐ Other_____

Do you have any existing life insurance or annuity contracts with this or any other company? ☐ Yes ☐ No

Do you intend with the purchase of this insurance to replace, terminate or change the value of any existing life insurance or annuity with this or any other company? ☐ Yes ☐ No

If "yes" provide information below for each policy or contract being replaced and attach any applicable replacement forms.

Insurance company name	Policy/Contract no.	Type of insurance being replaced

EMPLOYEE AND DEPENDENT DETAILS — Complete all details for individuals applying for coverage; list names of all dependents

Last name, first name, M.I.	Social Security no.	Sex	Date of birth	Age	Relationship	Height	Weight	State of birth	Eligible for federal income tax exemption?	Full-time student?
Employee name here		☐ M ☐ F			Self					
		☐ M ☐ F							☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F							☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F							☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F							☐ Yes ☐ No	☐ Yes ☐ No

List address of all dependents if different from the applicant, including temporary address (e.g. college student).

Last name, first name	Address
Last name, first name	Address

Are you or any dependent currently hospitalized? ☐ Yes ☐ No If yes, list name and reason: _____

SECTION 3: STATUS CHANGE

Reason for change:

☐ **Marriage** ☐ **Divorce** ☐ **Spouse deceased** ☐ **Birth/Adoption** ☐ **Termination of employment**

Date changed occurred	☐ Change name to:	☐ Change address to:

☐ Change of beneficiary **Complete section 4**	☐ Add/Delete dependents: (Include name and date of birth/adoption)	☐ Other change: (explain)

☐ Change coverage amount

Current benefit amount: $ _____ Change benefit amount to: $ _____

☐ Change life class to:

SECTION 4: BENEFICIARY DESIGNATION

	Last name	First name	M.I.	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						

SECTION 5: INSURANCE COVERAGES — Check all that you are applying for. Coverage is limited to what is selected and offered by the employer.

☐ Basic Life

☐ Basic AD&D ☐ Dependent Life

☐ Optional Life_____ x annual earnings OR $ _____

Optional Life (51+ lives only):

Spouse $ _____ Child $ _____

☐ Short term disability ☐ Long term disability

☐ Voluntary Life: _____ x annual earnings OR $ _____

☐ Voluntary AD&D: _____ x annual earnings OR $ _____

☐ Voluntary STD

☐ Voluntary LTD

Payroll deduction frequency:

☐ **Weekly** ☐ **Bi-weekly** ☐ **Semi-monthly** ☐ **Monthly** Monthly premium amount: $ _____

SECTION 6: LIFE PORTABILITY — Complete only if exercising portability option. Attach check with application.

Date coverage with employer terminated	Payment mode requested ☐ **Quarterly** ☐ **Semi-monthly** ☐ **Annual**

Coverage Transfer Options:

Minimum employee coverage is the lesser of the amount of coverage in-force or $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 7: AUTHORIZATION – Read carefully before signing

1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract, subject to change by my written notice to my employer.
2. 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.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. 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. I understand that I will have the opportunity to review any amendments.
5. I understand that Anthem Life & Disability 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 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, other than the exercise of the portability of insurance option, if applicable, 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 an otherwise valid claim to be denied under any insurance issued from this application, subject to the incontestability provision of the policy. This authorization, for purposes of processing this application form, is valid from the date signed for a period of twenty four months. I may revoke this authorization at any time by sending a written request to the Insurer. A photocopy is as valid as the original. I agree that this application will be attached to and made part of the certificate.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Payment of accelerated death benefits reduce life coverage amounts only by the amount of accelerated benefit paid. The Insurer does not discount or charge separate premiums or fees for accelerated death benefits.

Fraud Warning For Health Insurance Coverage: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of employee **X**	Date
Signature of spouse **X**	Date
Signature of dependent (if over the age of 14 years, 6 months) **X**	Date

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