Application For Group Insurance — CHEIBA Trust — Basic Life

Anthem® Life

SECTION 1: EMPLOYEE INFORMATION

Name of Institution

Effective date

Coverages applying for (if applicable)

☐ Life/AD&D ☐ Dependent Life

Last name	First name	M.I.	Payroll no. (if applicable)

Address	City	State	ZIP code

Social security no.	Sex ☐ Male ☐ Female	Date of birth

Date of employment

Earnings $____________________ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Semimonthly ☐ Yearly

Job title	Department	Hours worked per week excluding overtime

Primary beneficiary name (if married woman, give first, married and maiden name)	Birthdate	Relationship

Secondary beneficiary name (if married woman, give first, married and maiden name)	Birthdate	Relationship

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Group number	Billing unit number
Reference number (if applicable)	
Class number	G.I. code
Underwriting reason ☐ Small group ☐ Late enrollee ☐ ____% Emp paid ☐ Excess Amount________	Underwriting action ☐ Approved ☐ Declined Initials__________ Date__________
Effective date	
Life/AD&D ☐ Y ☐ N Amount______________________	
Supplemental ☐ Y ☐ N Amount______________________	
Dependent Life ☐ Y ☐ N Amount______________________	
STD ☐ Y ☐ N Amount______________________	
LTD ☐ Y ☐ N Amount______________________	
LTD Effective Date	
Process Date	Initials
☐ SH ☐ EP	

SECTION 2: EMPLOYEE SIGNATURE - Sign below if you are applying for coverage

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 meet the eligibility requirements of the employer. 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.

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.

Employee signature	Print name	Date signed
X		