

Employer Application



Group size 2-50 eligible employees

Please complete in blue or black ink and use extra sheets of paper if necessary

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Anthem use:					
Group/Account #	Approved SIC: (WI only - SIC applies to Life and Disability only)	Anthem's Approved Effective Date / /	State <input type="checkbox"/> Wisconsin <input type="checkbox"/> Missouri	Tracking ID	
1. Effective date					
Requested effective date: / /					
2. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.					
<input type="checkbox"/> Blue Access [®] (PPO) <input type="checkbox"/> Anthem ByDesign [®] (ABD) <input type="checkbox"/> Vision <input type="checkbox"/> Optional AD&D <input type="checkbox"/> Blue Access [®] Choice (PPO) (MO only) Buy-up/Health Saving Account (HSA) <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Blue Preferred [®] Plus (POS) <input type="checkbox"/> Lumenos [®] Health Saving Account <input type="checkbox"/> Basic Life <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Blue Preferred [®] (HMO) (MO only) <input type="checkbox"/> Lumenos [®] Health Reimbursement Account <input type="checkbox"/> Basic AD&D <input type="checkbox"/> Blue Priority [®] Plus POS (WI only) <input type="checkbox"/> Lumenos [®] Health Incentive Account <input type="checkbox"/> Dependent Life <input type="checkbox"/> Anthem Essential SM PPO <input type="checkbox"/> Lumenos [®] Health Incentive Account Plus <input type="checkbox"/> Optional Life <input type="checkbox"/> Anthem Essential SM Choice PPO (MO only) <input type="checkbox"/> DentaCare (HMO) (WI only) <input type="checkbox"/> EE only <input type="checkbox"/> Anthem Essential SM POS (WI only) <input type="checkbox"/> Dental Blue [®] 100 <input type="checkbox"/> SPS only <input type="checkbox"/> <input type="checkbox"/> Dental Blue [®] 200 <input type="checkbox"/> CHD only <input type="checkbox"/> <input type="checkbox"/> Dental Blue [®] 300 <input type="checkbox"/> SP/CHD					
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
Type of business					
Is any part of group subject to bargaining agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No		Will bargaining agreement participants be considered eligible employees? <input type="checkbox"/> Yes <input type="checkbox"/> 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.					
Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID no. and number of employees employed by each. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of current health and/or life carrier(s)			Next Renewal Date / /		
If Lumenos [®] HSA with Incentives is selected, Employer will provide the HSA plan through a cafeteria plan. Please check the box. <input type="checkbox"/> Yes			Do you want Anthem to facilitate opening a Health Savings Account with Mellon? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is your group subject to COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a COBRA administrator? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, do you want an Anthem affiliate to administer COBRA for your group? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete and sign the COBRA agreement.</i>	
List employee/dependents on Continuation of Coverage/COBRA			Names of persons in COBRA eligibility period		
4. Medicare Secondary Payer					
<input type="checkbox"/> Does not employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute (The group agrees to notify Anthem Blue Cross and Blue Shield as soon as this statement is no longer true.)					
<input type="checkbox"/> Does employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute					
5. Eligibility					
<i>Eligible full-time employees must work at least 30 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.</i>					
Number of full time employees (including those within their waiting period and individually contracted individuals)		Total number of employees (including part-time, seasonal and temporary (MO - include individually contracted))	Total number of employees not actively at work	Employees currently in their waiting period will have coverage effective: <input type="checkbox"/> On group's effective date <input type="checkbox"/> Same waiting period that applies to new persons or on group effective date, whichever is later	
New eligible enrollees will become effective on: (MO) the day after <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days of employment <i>or the first billing date after</i> <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days of employment (WI) the 1st of the month following <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other (no more than 180 days) <input type="checkbox"/> Date of hire <input type="checkbox"/> Waive probationary Period					
Do any classes of employees have a different waiting period? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, explain		

In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE[®] Managed Care, Inc. (RIT), Healthy Alliance[®] Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association, ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare"), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

6. Contribution and Minimum Participation Requirements *Employer must have at least two 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 (MO only). If group contribution is 100%, 100% participation is required (N/A WI). Group minimum participation for Health: the greater of 75% of "Net 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 (N/A WI). For Life and Disability participation requirements, please refer to the Benefit Plan highlights on your proposal.

Group contribution level for insurance
 Health _____% Dental _____% Basic Life _____% Basic AD&D _____% Dependent Life _____% Optional Life _____%
 Optional AD&D _____% STD _____% LTD _____%
 WI only: Flat Dollar Amount (Minimum \$100 per employee per month): \$_____ Other: _____
(Dental/Vision contributions should match the medical; however, when it does not, it must be at least 25 percent of the total, but not less than 50 percent of the single rate.)

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

7. Participation Requirements (WI Only)

These participation requirements must be observed and maintained for a Group to remain eligible for coverage. It is the Group's responsibility to maintain these requirements. The number of employees in medical coverage initially and when reviewed periodically thereafter determine the size of group for participation requirement purposes.

Group Size*	Participation Required	
2-4	2	
5-6	3	
7	4	
8-9	5	
10	6	
11 & Up	70%	*Eligible employees
<i>For Non-Small Employers:</i>	75%	<i>Small Employer has the meaning given in Wis. Stat. s.635.02(7).</i>

- a. Eligible employees who waive coverage due to coverage under a health plan that constitutes "creditable coverage" for pre-existing condition purposes (e.g., COBRA, spouse's group health coverage) will not be used to determine participation.
- b. For Small Employers, an employee who waives coverage because the employee's annual premium exceeds 10% of the employee's annual gross earnings will not be used to determine participation.
- c. For all groups, eligible employees who waive coverage because they are part of another health plan offered by the Group will be used to determine participation.

8. Signature PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM (Read Section 9, below, carefully before signing)

Signature and title of authorized group representative	Print name of authorized group representative	City/state where signed	Date / /
Accepted by Anthem's Underwriting Department — Signature and title			Date / /

9. 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 represents the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative represents on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, 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 statement 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. (Does not apply in Wisconsin)
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 that 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

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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 hours per week if the employer is located in Wisconsin, or work 30 or more hours per week if the employer is located in Missouri (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: MO - 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. In Wisconsin, a small employer is defined as an employer that employed an

average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employees on the first day of the plan year.

- 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.
- 17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.

10. Broker Representation - I hereby represent 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 a 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	Broker e-Mail address	Date / /
Agency name (if applicable)		General agency broker	
Address		Anthem sales representative	

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