



SUPPLEMENTAL ENROLLMENT FORM
PLEASE COMPLETE IN INK.

Read and complete all of this form. If you need more space attach a separate sheet of paper. Please use 4 digits for years (e.g. 1998, not 98)

Anthem Life Insurance Company
 P.O. Box 182361
 Columbus, OH 43218-2361
 800-551-7265 Fax 614-433-8880

SECTION A: INSURANCE COVERAGES (Check all that you are applying for)

- Supplemental Life & AD&D Employee Coverage Amount: _____
- Supplemental Life & AD&D Spouse Coverage Amount: _____ (Cannot exceed Employee Amount)
- Supplemental Life & AD&D Child(ren) Coverage Amount: _____

SECTION B: TO BE COMPLETED BY EMPLOYEE

- REASON FOR APPLICATION
- New Enrollment
 - Change of Status
 - Change of Beneficiary
 - Waive Life Coverages (complete Section G)
 - Change of Coverage
 - Change of Class
 - Change of Name/Address
 - Portability Option (complete Sections B,E,F)

Social Security Number		Last Name, First Name, MI			Home Telephone Number	
Street Address		City	State/Zip	Date of Birth	County	
Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, state reason:		Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Employer Name Chabot-Las Positas CCD	Date of Hire	Business Telephone	Fax #	E-mail Address		
Hours worked per week:		Occupation:	Yearly Income:			

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

Last Name, First, MI	Social Security #	Gender	Date of Birth	Age	Relationship	Height	Weight	State of Birth	Full-time Student

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

Name/address: _____

Name/address: _____

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

SECTION C: STATUS CHANGE

Reason for status change:	Marriage	Divorce	Termination of Employment:
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Date Change Occurred: _____

- Change Name To: _____
- Change Address To: _____
- Change of Beneficiary (complete section D): _____

SECTION D: BENEFICIARY DESIGNATION

Primary: Name: _____ Age: _____ Relationship: _____ Percent: _____
Name: _____ Age: _____ Relationship: _____ Percent: _____
Name: _____ Age: _____ Relationship: _____ Percent: _____
Name: _____ Age: _____ Relationship: _____ Percent: _____

Contingent: Name: _____ Age: _____ Relationship: _____ Percent: _____
Name: _____ Age: _____ Relationship: _____ Percent: _____
Name: _____ Age: _____ Relationship: _____ Percent: _____

SECTION E: PORTABILITY (Complete only if exercising portability option. Attach check with application.)

Date coverage with Employer terminated: _____ Payment Mode Requested: Quarterly Semi-Annual Annual

Coverage Transfer Options: (Minimum employee coverage is \$20,000 and employee coverage is required to transfer any dependent coverage. Dependent coverage may not exceed 50% of employee coverage.)

Employee Same Decrease to: _____ Delete coverage
Spouse Same Decrease to: _____ Delete coverage
Child(ren) Same Decrease to: _____ Delete coverage

SECTION F: 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 coverage, 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 application.
5. I understand that Anthem Life 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 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 denial or benefits or rescission or cancellation of my coverage(s). The authorization for purposes of processing this application form, is valid from the date signed for a period of thirty months. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my child(ren) and my spouse (if spouse does not sign below), if covered by the Plan. I am acting as their agent and representative.

Print Name: _____ Social Security Number: _____

Signature: _____ Date: _____

Spouse Print Name: _____

Spouse Signature: _____ Date: _____

SECTION G: WAIVER OF LIFE COVERAGE

I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Print Name: _____ Social Security Number: _____

Signature: _____ Date: _____

The laws of some states require us to provide you with the following information:

In Indiana and Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Kentucky: Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance 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.