Life Insurance Enrollment

Anthem Blue Cross

INSTRUCTIONS:

For selecting benefits, please complete and sign Sections 1-3 and 5. Be sure to complete coverages selected and indicate benefit amount.
If declining coverage, complete Sections 1, 2 and 4.

☐ New Enrollment ☐ Re-hire ☐ Re-enrollment | Group no.

SECTION 1: PERSONAL INFORMATION

Last name	First name	MI	Social security no.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)

Street address	City	State	ZIP code

Phone no.	Employer	Date of hire/rehire (MM/DD/YYYY)	Are you retired? ☐ Yes ☐ No	Date of retirement (MM/DD/YYYY)

Job title	Dept no.	Class	Annual salary	Marital status ☐ Single ☐ Married ☐ Divorced

SECTION 2: COVERAGE ELECTION

Complete the boxes by checking them to indicate your Coverage Election. All the coverages listed may not be offered under your plan. To elect dependent coverage, the corresponding employee coverage must be selected.

Elected Benefit	Benefit Amount	Refused	Elected Benefit	Benefit Amount	Refused
☐ Basic life (AD&D)		☐	☐ Optional AD&D - employee		☐
☐ Dependent life		☐	☐ Voluntary AD&D - employee		☐
☐ Optional life - employee		☐	☐ Voluntary AD&D - spouse		☐
☐ Optional dependent life/spouse		☐	☐ Voluntary AD&D - child		☐
☐ Optional dependent life/child		☐	☐ Voluntary short term disability		☐
☐ Short term disability		☐	☐ Voluntary long term disability		☐
☐ Long term disability		☐	☐ Other		☐

SECTION 3: BENEFICIARY EMPLOYEE LIFE DESIGNATIONS

Primary Beneficiary – First to receive payment (required) – If more than one beneficiary is named, enter a percentage for each.
*Note dependent life payments are always paid to the employee.

☐ Named individuals (enter name, address, date of birth, Social Security number and relationship to the insured for each name listed.)

Last name	First name	Date of birth	Social security no.	Relationship	%

Street address	City	State	ZIP code

Last name	First name	Date of birth	Social security no.	Relationship	%

Street address	City	State	ZIP code

☐ Estate of insured

☐ Revocable or irrevocable trust (Enter the name of the Trustee, name of Trust and complete date of trust.)

☐ Trustee under insured's Will (If choosing this option DO NOT enter additional names in the primary beneficiary field.)

Please send completed form to Anthem Blue Cross Life and Health Insurance Company.

SECOND BENEFICIARY (Second to receive payment (optional) – If more than one beneficiary is named, enter a percentage for each.)

☐ **Named individuals (enter name, address, date of birth, Social Security Number and relationship to the insured for each name listed.**

Last name	First name	Date of birth	Social security no.	Relationship	%

Street address	City	State	ZIP code

Last name	First name	Date of birth	Social security no.	Relationship	%

Street address	City	State	ZIP code

☐ Estate of insured

☐ Revocable or irrevocable trust (Enter the name of the trustee, name of trust and complete date of trust.)

☐ Trustee under insured's Will (If choosing this option DO NOT enter additional names in the primary beneficiary field.)

Section 4: DECLINATION OF COVERAGE (Signature required)

I hereby decline insurance for the group life coverages which I have refused. This refusal of coverage applies to myself as well as any of my eligible dependents (if applicable). I understand that if I wish to apply for this coverage at a future date, I will then have to comply with the rules governing late applications.

Signature	Date (MM/DD/YYYY)
X	

Section 5: EMPLOYEE AUTHORIZATION (Signature required)

I hereby apply for the insurance for which I am now or may become eligible under the group policy or policies issued to the policyholder by Anthem Blue Cross Life and Health Insurance Company. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance, which authorization may be revoked by me at any time by prior written notice to the policyholder. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I again apply for insurance in accordance with the terms of the group policy. To the best of my knowledge and belief, the information I have provided on this form is complete and correct.

Employee's signature	Date (MM/DD/YYYY)
X	