Empire BlueCross
Anthem Life & Disability Insurance Company
Large Group Member Enrollment/Change Form

Empire BlueCross BlueShield — An Anthem Company

Anthem Life

Anthem Life & Disability Insurance Company underwrites Life and Disability products. Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc. underwrite medical, dental, vision, group accident, specified di ease and hospital indemnity insurance products.

Thank you for choosing Empire BlueCross BlueShield (Empire) and Anthem Life & Disability Insurance Company (Anthem Life).
So that we may quickly and accurately process your enrollment, please complete in full and sign in section 8.

Section 1: Reason for enrollment/change — Please complete section A, B or C.

A. New enrollment/addition — Choose only one reason in bold.

☐ **New hire** – Must indicate start date of full-time employment in section 9. Leave ***Date of change*** fi ld blank. **Date of change:** _____ (MMDDYY)
☐ **Open enrollment** – Leave ***Date of change*** fi ld blank.
☐ **Status change** – Select only one.
☐ Marriage ☐ Newborn ☐ Adoption ☐ Retirement ☐ Medicare eligible For ***Medicare eligible*** only, answer the following questions:
Eligibility criteria – Select only one ..... ☐ Age 65+ ☐ Disability ☐ ESRD: Onset date: _____
Active employee? ..... ☐ Yes ☐ No
Electing company coverage as primary coverage? ..... ☐ Yes ☐ No
Electing Medicare-related coverage as primary coverage? ... ☐ Yes ☐ No
(If company size is under 20 employees and end-stage renal disease does not apply, you must choose this option)
☐ **Age 29 Adult Dependent Election** – Must complete section 4.
☐ **Original COBRA/NYS Continuation of coverage:** _____ (MMDDYY)
Nature of COBRA/NYS event: _____
☐ **Loss of Coverage** – Must indicate last day covered in section 6.
☐ **Waive Life coverage**
☐ **Other:** _____

B. Change — Check all that apply. For all checked boxes below, please supply new information in sections 4 and 5.

☐ Name ☐ Primary Care Physician (PCP) (POS plans only) **Date of change:** _____ (MMDDYY)
☐ Address ☐ Managed Dental Primary Care Dentist (PCD) (If your company offers an Empire Dental plan)
☐ Change Life and/or Disability insurance classific tion from Class _____ to Class _____

C. Cancel coverage — Select only one.

Note: If you are canceling your own coverage, please have your employer fill ut an *Employee Termination Form*. For other cancellations, please check the appropriate box below and enter the name in the Applicant and Family portion in section 5.

Spouse/Dependent ☐ Death ☐ Divorce ☐ Dependent no longer eligible **Date of event:** _____ (MMDDYY)
☐ Other: _____

Section 2: Benefits election

Medical insurance — Select only one plan type.

Large group plans (101+ eligibles)

☐ Empire EPO – (Copay/Deductible/Coinsurance)
☐ Empire EPO – (Copay)
☐ Empire PPO – (Copay/Deductible/Coinsurance)
☐ Empire PPO – (Copay)
☐ Empire PPO with HSA
☐ Empire PPO with HRA
☐ Empire EPO with HSA
☐ Empire EPO with HRA
☐ Empire EPO with HSA – (Copay)
☐ Empire EPO with HRA – (Copay)
☐ Empire EPO – (Deductible/Coinsurance)
☐ Empire PPO – (Deductible/Coinsurance)
☐ Empire EPO with HRA – (Deductible/Coinsurance)
☐ Empire PPO with HRA – (Deductible/Coinsurance)
☐ Empire Blue Access EPO – (Copay Plan)
☐ Empire Blue Access EPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access EPO – (Copay w/Deductible)
☐ Empire Blue Access EPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access EPO with HRA – (Ded/Coins)
☐ Empire Blue Access EPO with HRA – (Ded/Coins w/Copays)
☐ Empire Blue Access EPO with HSA – (Ded/Coins)
Other: _____

☐ Empire Blue Access GEPO – (Copay Design)
☐ Empire Blue Access GEPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access GEPO – (Copay w/Deductible)
☐ Empire Blue Access GEPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access GEPO with HRA – (Ded/Coins)
☐ Empire Blue Access GEPO with HRA – (Ded/Coins w/Copays)
☐ Empire Blue Access GEPO with HSA – (Ded/Coins)
☐ Empire Blue Access PPO – (Copay)
☐ Empire Blue Access PPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access PPO – (Copay w/Deductible)
☐ Empire Blue Access PPO – (Copay/Deductible/Coinsurance)
☐ Empire Blue Access PPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access PPO with HRA – (Deductible/Coinsurance)
☐ Empire Blue Access PPO with HSA – (Deductible/Coinsurance)
☐ Empire Connection EPO – (Prism/Direct Connect/Deluxe)
☐ Empire Connection EPO – (Copay Design for 0% Coins Plans)
☐ Empire Connection EPO – (Copay Design)
☐ Empire Connection EPO – (Copay w/Deductible)
☐ Empire Connection GEPO – (Prism/Direct Connect/Deluxe)
☐ Empire Connection GEPO – (Copay Design for 0% Coins Plans)
☐ Empire Connection GEPO – (Copay)
☐ Empire Connection GEPO – (Copay w/Deductible)

Select only one medical coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Section 2: Benefits election – Continued.

Dental insurance[1]

☐ Empire Dental Prime
☐ Empire Dental Complete
☐ Empire Dental Premium Care (PPO)
☐ Empire Dental XPO
☐ Empire Dental Consumer Choice PPO
☐ Empire Dental Essential Choice PPO
☐ Empire Dental Enhanced Choice PPO
☐ Empire Dental Essential Care (managed care)
☐ Empire Dental Enhanced Care PLUS (managed care)
☐ Empire Dental Enhanced Care (managed care)
☐ Empire Dental Comprehensive Care (managed care)

Select only one dental coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Vision insurance[2]

Blue View Vision℠ Select only one vision coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Flexible Spending Account (FSA)

☐ Healthcare FSA (excluded if you have an HSA plan) ☐ Limited-Purpose FSA for dental and vision services only (with an HSA plan)

Life and Disability coverage

☐ Basic Life
☐ Basic Life and Accidental Death and Dismemberment (AD&D)
☐ Basic Dependent Life
☐ Supplemental/Voluntary Life and AD&D . . . . $_______________ (employee amount)
☐ Supplemental/Voluntary Dependent Life Spouse. . . . . . $_______________ (spouse amount)
☐ Supplemental/Voluntary Dependent Life Child. . . . . $_______________ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . . $_______________ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income	Occupation	Life and disability class no.
$________________		

Benefic ary designation – Attach a separate sheet if necessary.

☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City	State	ZIP code	Percentage	
☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City	State	ZIP code	Percentage	
☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City	State	ZIP code	Percentage	
☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City	State	ZIP code	Percentage	

Total percentages must add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary su vives, the proceeds will be paid to the contingent beneficiary(i s) listed above. Beneficia ies may be changed by the insured's written notice to his or her employer.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary or 50% or more of your benefit a ount. Please have your spouse read and sign the following.

Authorization

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary f group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Spouse signature	Spouse name (print)	Date (MMDDYY)
X		

1 If your company offers an Empire Dental plan.
2 If your company offers a Blue View Vision plan.

Section 3: Voluntary Accident, Specified Di ease, and Hospital Indemnity Insurance

☐ Voluntary Accident Insurance – Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ Voluntary Specified Dise se Insurance – Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Specified Dise se plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: ______________________________

☐ Voluntary Hospital Indemnity Insurance – Coverage option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Specified Dise se or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits rom an individual or group health insurance policy or an employer sponsored health plan that provides essential health benefits ☐ No ☐ Yes (Please note that if the response is No, such applicants are not eligible for coverage)

Will all applicants who reside in NY, when such coverage is to become effective, be enrolled under or have another application(s) pending for any other specified dise se policy that is not being replaced in full by this coverage? **(Please note that if the response is Yes, such applicants may not be eligible for coverage)** ☐ No ☐ Yes

Applicants residing in NY: As of the date of this application, total number of specified dise ses for which all applicants have specified dise se coverage in force or have another application(s) pending for any other specified dise se policy: Employee: ________ Spouse: ________ Child(ren): ________

List specific specified dis ses for which all applicants have specified dise se coverage in force or have another application(s) pending for any other specified dise se policy (list applicable conditions):

Employee: ______________________________

Spouse: ______________________________

Child(ren): ______________________________

Benefic ary designation — Attach a separate sheet if necessary.

☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage
☐ Primary ☐ Contingent	Name of benefic ary	Date of birth	Social Security no.		Relationship to applicant	Age
	Street address	City		State	ZIP code	Percentage

Total percentages must add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary benefic ary survives, the proceeds will be paid to the contingent benefic ary(ies) listed above. Benefic aries may be changed by the insured's written notice to his or her employer.

Section 4: Applicant information

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Marital status ☐ Single ☐ Married	Marriage date (MMDDYY)	Primary phone no.

Street address	Apt. no.

City	State	ZIP code

Occupation	Primary language

Email address[2]

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Section 5: Family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets, if necessary.

To select a PCP and/or PCD, visit our website at empireblue.com/find-doctor. If your Empire benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Applicant

Primary care physician (PCP) last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

Primary care dentist (PCD) last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

☐ **Spouse** ☐ **Domestic partner**

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Email address is required for the applicant.
3 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
4 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 1

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 2

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 3

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 4

Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 6: Other medical coverage information — This section must be completed.

The questions in this section are for informational purposes only. The answers provided will have no bearing on eligibility.

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐ No **If yes, please complete the following:**

Name(s) of person(s) (fi st, M.I. last)	Insurance company name	Coverage dates	Provided by employer?	Employment status	Contract type
Self	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
☐ Spouse ☐ Domestic Partner	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 1	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 2	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 3	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)

Prior and other dental coverage information

Has any person applying for coverage had prior or other dental insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Carrier name: _____ Carrier phone no.: _____ Member ID: _____

Date coverage began: ____ ____ ____ Date ended: ____ ____ ____ (MMDDYY)

Included orthodontia? ☐ Yes ☐ No

Section 7: Electronic Notice — This section is optional.

I'm signing here because I want to get information about my benefits by mail or electronically. This may include my certific te or evidence of coverage, explanation of benefits s atements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Empire has my most up to date email. These electronic communications may include specific d tails about me and my plan. I know I can change my mind at any time or request a free copy of specific aterials by mail. I'll just contact Empire and/or Anthem Life to do either.

Applicant signature	Date (MMDDYY)
X	

Section 8: Terms, Conditions and Authorizations

Please read this section and the Insurance Fraud Statement below carefully before signing the application.

I am electing coverage as an employee, or former employee, retiree, current or former dependent of an active employee, or retiree, and am eligible for group coverage under the terms and conditions of the group's contract(s). I make this election on behalf of all eligible dependents and myself. I understand that I am under a continuing obligation to notify the group of a change in my, or my dependent's, status; such change may result in a change of insurance status with Empire or Anthem Life & Disability Insurance Company (Anthem Life) and that failure to make such notific tion may result in cancellation of the coverage by either carrier, subject to the incontestability clause of the contract.

I understand that if I become Medicare eligible while I am covered under the medical contract, any benefits I am e titled to under that contract will be reduced by the amounts paid by Medicare for those services, whether or not I apply for or submit a claim to Medicare.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affili ted with Anthem Life, or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Anthem Life, its affili tes, and any administrators, reinsurers, agents, providing services on behalf of Anthem Life, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, and HIV/AIDS information, but excluding psychotherapy notes, and excluding substance use disorder records) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem Life representatives to evaluate and adjudicate my current application for life or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, fi ancial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem Life solely to assist with the evaluation and adjudication of my current life or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards to any re-disclosed protected health information as applicable. I understand that Anthem Life may collect information about me, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws; any disclosure to third parties will be made in accordance with state and federal law. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 24 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits u der an insurance policy, this authorization shall remain valid for the term of coverage of the policy for a disability insurance benefit a d for the duration of the claim if the claim is not for a disability insurance benefi . A photocopy and/or electronic copy is as valid as the original. The applicant or the applicant's authorized representative is entitled to receive a copy of this authorization.

If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, the insurers shall notify the employer of such differences, and seek the enrollees written consent to issue the different coverage.

I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

All statements and answers in this notice of election are true. Any material misrepresentation may result in Empire's or Anthem Life's cancellation of coverage which may result in an otherwise valid claim to be denied. The material misrepresentation must also be intentional in order to void the insurance contract or defeat recovery.

I certify each Social Security number submitted is correct.

Insurance Fraud Statement (does not apply to Life Insurance): Any person who knowingly and with intent to defraud an insurance company or other person fi es an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact there to, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim or each such violation.

Applicant signature	Print name	Date (MMDDYY)
X		

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

This is ACCIDENT insurance only. This is a supplement to health insurance and is NOT a substitute for major medical or other comprehensive health insurance coverage. This policy only pays benefits elated to a covered accident. IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Important Specified Di ease Insurance eligibility information:

The following notice(s) apply to all Specified Di ease and Voluntary Specified Di ease coverage presented on this form:

SPECIFIED DISEASE insurance is a supplement to health insurance and is NOT a substitute for major medical coverage. This is not a qualifying health coverage ("minimum essential coverage") that satisfi s the health coverage requirement of the affordable care act. If you don't have minimum essential coverage, you may owe an additional payment with your taxes.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

This is HOSPITAL INDEMNITY insurance only. This is a supplement to health insurance and is NOT a substitute for major medical or other comprehensive health insurance coverage. It pays a fi ed dollar amount for covered benefits with ut regard to the health care provider's actual charges. The benefit p yments are not intended to cover the cost of your medical care. These benefits a e paid in addition to any other health insurance coverage you may have.

Section 9: Employer information — This section must be filled in by our group benefits dministrator.

Group name		Group no.	Group sub no.
Street address	City	State	ZIP code
Employee no.	Payroll/Department location		Applicant's full-time employment start date
Authorized Group Benefits dministrator signature **X**	Print name		Date (MMDDYY)