# Employer Application
## Association Health Plan Coverage
## Kentucky

Anthem® AnthemLife®

Please complete electronically, or in blue or black ink only.

Group no.

### Section 1: Company information

| | | |
|---|---|---|
| ☐ New enrollment ☐ Renewal/Plan amendment | Benefit year ☐ Calendar year ☐ Plan year | Requested effective date (MM/DD/YYYY) |
| Applicant (legal name of group) | | Tax ID/FEIN (required) |
| Name of association (if applicable) | | |
| Company street address | | |
| City | County | State / ZIP code |
| Billing address – If different from above | | |
| City | County | State / ZIP code |
| Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Limited Liability Company (LLC) ☐ Labor union ☐ Trust ☐ Government unit/agency ☐ Other: _____ | | |
| SIC code – Required | Type of business | No. of years in business |
| Group administrator name | | Primary phone no. |
| Email address | | Fax no. |
| Additional company contact name | | |
| Email address | | Primary phone no. |
| Current group carrier | Current carrier effective date | Type of coverage / Type of funding |
| **Is any part of group subject to bargaining agreement?** ☐ Yes ☐ No<br>**Will bargaining agreement participants be considered eligible employees?** ☐ Yes ☐ No | | |
| Union name (attach copy of agreement) | Union no. | Contract expiration date |

Reset Form Save and Print

Group no.

## Section 1: Company information — Continued

List all affiliates/subsidiaries/divisions (list names, locations, no. employed at each location.) Attach a separate page to show any separate billing addresses, and any separate billings for life classes.

| Names of affiliates/subsidiaries/divisions | Location | No. of employees per location |
|---|---|---|
| | | |
| | | |
| | | |

| Total no. of employees residing/working outside of home office state | List no. of employees at each office location |
|---|---|
| | |

Has your group been turned down for coverage in the last 12 months? ☐ Yes ☐ No

If yes, by whom, when, and why? _____

Will any insurance carrier(s), in addition to Anthem, provide medical coverage as part of the group's employee benefit plan? ☐ Yes ☐ No

If yes, list carrier(s) and product(s) offered: _____

In the past 36 months, has the company or any affiliate entity filed for protection or operated under federal/state bankruptcy laws (Chapter 11 or 7) or state receivership? ☐ Yes ☐ No

In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity to be placed voluntarily into bankruptcy? ☐ Yes ☐ No

## Section 2: Type of coverage

### Medical coverage

**Association Health Plan Coverage options**

☐ Anthem Essential (PPO)
☐ Blue Access (PPO)
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA (with Copay)
☐ Blue Access PPO HRA (with Copay)

**For CDHP accounts (HSA/HRA) plans:**

Do you want Anthem to facilitate opening a Health Savings Account Financial Custodian (bank) account? ☐ Yes ☐ No

If yes, requires completion of questionnaire.

### Flexible Spending Account (FSA) coverage — Multiple plans can be selected.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

### Dental coverage

☐ Prime Essential Choice Quote ID: _____
☐ Other: _____ Quote ID: _____
☐ Complete Essential Choice Quote ID: _____

### Vision coverage

☐ Vision

### Contribution requirements

**Choose your group contribution level for each month:**

Medical: _____% per employee _____% per dependent (optional)

Dental: _____% per employee _____% per dependent (optional)

Vision: _____% per employee _____% per dependent (optional)

Do any classes have a percentage of group contribution different than above? ☐ Yes ☐ No

If yes, explain: _____

Group no.

**Life and disability coverage — Please check all that apply and attach your quote/proposal with the application. A minimum of two employees must enroll.**

| Life/AD&D products | | Disability products | |
|---|---|---|---|
| **Choose life product and group contribution percentage:** | | **Choose disability product and group contribution percentage:** | |
| ☐ None | | ☐ None | |
| ☐ Basic Life | _____% | ☐ Short Term Disability | _____% |
| ☐ Basic Life & AD&D | _____% | ☐ Long Term Disability | _____% |
| ☐ Basic Dependent Life | _____% | ☐ Voluntary Short Term Disability | _____% |
| ☐ Optional Supplemental/Voluntary Life and AD&D | _____% | ☐ Voluntary Long Term Disability | _____% |
| ☐ Optional Supplemental/Voluntary Dependent Life | _____% | | |

If disability benefits are selected, indicate whether the employee pays disability premiums on a pre- or post-tax basis. If it varies by class, attach additional page with class-level information.

Short Term Disability: ☐ Pre tax ☐ Post tax
Long Term Disability: ☐ Pre tax ☐ Post tax
Voluntary Short Term Disability: ☐ Pre tax ☐ Post tax
Voluntary Long Term Disability: ☐ Pre tax ☐ Post tax

## Life and/or disability probationary period/waiting period

Would you like to waive the probationary period/eligibility waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility waiting period for new eligible employees enrolling in life and/or disability plans after the group's coverage effective date the same as the Anthem medical policy eligibility period? ☐ Yes ☐ No

If no, enter the life and disability eligibility probationary period below. Attach additional page if more than three classes.

| Class number | Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.) | Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.) |
|---|---|---|
| | | |
| | | |
| | | |

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible employees is 30 hours per week unless otherwise indicated.

## Prior coverage

Do you have any existing life insurance or disability insurance with this or any other company? ☐ Yes ☐ No

Do you intend with the purchase of this insurance to replace, terminate or change the value of any existing life insurance or disability insurance with this or any other company? ☐ Yes ☐ No

If yes, provide information below for each policy or contract being replaced and attach any applicable replacement forms:

| Will this plan replace current? | Insurance company name | Policy/contract no. | Termination date (MM/DD/YYYY) |
|---|---|---|---|
| Life/AD&D coverage ☐ Yes ☐ No | | | |
| Disability coverage ☐ Yes ☐ No | | | |

## Participation requirements

Refer to the Life and Disability Proposal for life and disability participation requirements.

Group no.

## Not actively-at-work requirements for life & disability products

The employees listed below are not presently actively at work and/or are not expected to be actively at work on the requested group effective date. Anthem Life Insurance Company (Anthem Life) may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied. 1) The employee's absence must be due to illness or injury. 2) The employee must be covered by the prior carrier on the day immediately prior to Anthem Life's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at-work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Anthem Life's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

| Employee name | Amount of insurance | Date of birth | Last date worked | Reason not working | Date expected to return | Insured by prior carrier | Request actively-at-work waiver | For Anthem use only. Waiver request approved | For Anthem use only. Underwriter approval |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |

## Group Accident, Critical Illness, and Hospital Indemnity Insurance

Refer to sold case proposal for plan details.

☐ Accident Insurance – Contract code 1: _____ Contract code 2: _____ Contract code 3: _____

☐ Critical Illness Insurance – Contract code 1: _____ Contract code 2: _____ Contract code 3: _____
☐ Tobacco rated ☐ Uni-Tobacco

☐ Hospital Indemnity Insurance – Contract code 1: _____ Contract code 2: _____ Contract code 3: _____

## Medicare Part D coverage

Prescription drug benefits: ☐ Wrap ☐ Waiver ☐ Subsidy

If subsidy (CMS Information needed): Plan sponsor ID: _____ Application ID: _____
Unique benefit option identifier: _____

Group no.

## Section 3: Eligibility

Eligible full-time employees must work at least 30 hours per week, must be actively at work and must have satisfied any applicable eligibility waiting period. Eligible full-time employees do not include temporary or seasonal employees.

Total number of employees (including part-time): _____

Total number of full-time employees (including those within their waiting period): _____

Total number of full-time employees in employee waiting period: _____

Probationary period/waiting period for eligible enrollees:

☐ None ☐ First of month after hire date ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days

Do any classes of employees have a different waiting period? ☐ Yes ☐ No If yes, explain:

New eligible enrollees will become effective on:

☐ Day following completion of waiting period/probationary periods **(required for selection of 90 day waiting period)**

☐ First of month following completion of waiting period/probationary period

Do you wish to offer coverage for domestic partners? ☐ Yes ☐ No Note: Domestic partner coverage is not available for life and disability plans.

Is your group subject to COBRA? ☐ Yes ☐ No

Do you have a COBRA administrator? ☐ Yes ☐ No

Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No If yes, please complete and sign the COBRA agreement.

| List employees/dependents on Continuation of Coverage/COBRA | Name of persons in COBRA eligibility period | List all totally disabled employees and dependents |
|---|---|---|
| | | |
| | | |
| | | |

ERISA qualified? ☐ Yes ☐ No

Employee termination effective date: ☐ End of month ☐ End of day

## Section 4: Open enrollment — Does not apply to Life and Disability coverage.

Our standard open enrollment period is at least 31 days prior to the group's renewal date and 31 days following, which is held no less frequently than once in any 12 consecutive months. If you want to designate a different open enrollment period, please indicate the following:

Start date: | | | | | | | | End date: | | | | | | | | (MM/DD/YYYY)

Group no.

## Section 5: 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 certifies the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, 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 statements 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.
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 than 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' application or failure to report new medical 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 and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligible waiting period.
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.
18. STD benefits for employees eligible for state disability plans in CA, HI, NJ, NY, PR or RI will be integrated with the state mandated program in that state. The volume calculated for monthly premium will be based on the total benefit amount, and not reduced by the state mandated benefit.

**Fraud notice**

Any person who knowingly and with intent to defraud an insurance company, health maintenance organization or other person files an application for insurance or other form of health coverage 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.

## Section 6: Signature – Please attach a check for the first month's premium. Read section 5 carefully before signing.

| Printed name of authorized group representative | Title | |
|---|---|---|
| Signature of authorized group representative<br>**X** | | Date (MM/DD/YYYY) |
| Accepted by Anthem's Underwriting Department – Signature<br>**X** | Title | Date (MM/DD/YYYY) |

Group no.

## Section 7: Agent/producer/broker certification

**I certify that:**

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. 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.
3. I have not signed any of the applications for a group representative or individual applicant.
4. 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 and approves the application and the group receives a written notice and contract from Anthem.

**Are commissions paid to the agent or agency?** ☐ Agent ☐ Agency

| **Writing payable/sub-agent/producer/broker** | | | **Second writing payable/sub-agent/producer/broker** | | |
|---|---|---|---|---|---|
| **Split commission percentages:** Medical: _____% Dental: _____% | | | **Split commission percentages:** Medical: _____% Dental: _____% | | |
| Agency name | Agency ID no. | | Agency name | Agency ID no. | |
| Agent/producer/broker name | Agent ID no. | | Agent/producer/broker name | Agent ID no. | |
| Commissions paid to tax ID (must match designation above) | | | Commissions paid to tax ID (must match designation above) | | |
| Agent/producer/broker street address | | | Agent/producer/broker street address | | |
| City | State | ZIP code | City | State | ZIP code |
| Agent/producer/broker phone no. | | | Agent/producer/broker phone no. | | |
| Agent/producer/broker email address | | | Agent/producer/broker email address | | |
| Signature | Date (MM/DD/YYYY) | | Signature | Date (MM/DD/YYYY) | |

| **For general agent/producer/broker use only** | | |
|---|---|---|
| General agent/producer/broker name | Agent/producer/broker ID no. | |
| Street address | City | State ZIP code |

| **Sales representative** | |
|---|---|
| Sales representative name | Sales representative ID no. |

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd. Louisville, KY 40223
Anthem Life Insurance Company: P.O. Box 105448, Atlanta, GA 30348-5448