



Anthem Life Insurance Company

[PO Box 12345
Worthington, OH 43085]

Welcome

[State]¹ Individual Term Life Application and Change Form

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at [1 (xxx) xxx-xxxx]². But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** life coverage or to **change** existing life coverage with Anthem Life Insurance Company (Anthem Life). Answer all questions. Please print clearly using blue or black ink only.

You can apply or change coverage:

1. For new coverage:

- Coverage is available to applicants ages 18-64.
- You can apply any time during the year.
- If you apply with medical, your effective dates will match.
- If you apply without medical, your coverage will start on the 1st of the month following the date we receive your completed application (including payment).
- Payment must be included with your application. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check or money order until you've been enrolled.

2. For changes in coverage:

- You can change your coverage any time throughout the year.
- If you are requesting to increase your coverage, you must reapply for coverage and complete the application process.
- If you are requesting to decrease your coverage, you will need to complete Sections 1, 2a and 6.
- If you are requesting a change in beneficiary, you will need to complete Sections 1 and 4.
- The change in coverage will be effective the first day of the month following the month in which we receive your request for change.

Tips when filling out this form

1. Answer all questions. [Please print clearly using blue or black ink only.]³
2. Please submit all pages.
3. You can also apply online at Anthem.com

Some frequently asked questions

1. Do I need to include a payment?

Yes. We can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check or money order until you've been enrolled.

2. Does this coverage accumulate a cash value?

No. This is a term life policy and pays benefits only upon death of the insured.

3. Do I need to provide my Social Security Number?

No. You are not required to provide your Social Security Number to apply for life insurance.

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Step 1: Who is applying?

| Section 1: Applicant Information | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|-----------------------------------|
| Application Type (select one): <input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage <input type="checkbox"/> Change in Beneficiary | | | | | | Policy #: (Change Request Only) | |
| Last Name (Legal Name) | | | First Name (Legal Name) | | | M.I. | Social Security Number (Optional) |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married/Domestic Partner <input type="checkbox"/> [Civil Union] ⁴ | | Sex/Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth (mm/dd/yyyy) / / | Residency: Are you a legal resident of the United States and of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | County (for home address) | |
| Home address (not a P.O. Box) | | | | City | | State | ZIP |
| Billing address (optional – complete if different than your home) | | | | City | | State | ZIP |
| Mailing address (optional – complete if different than your home) | | | | City | | State | ZIP |
| Primary phone | | Secondary phone | | Email | | | |
| [<input type="checkbox"/> Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the translator must sign and submit a “Statement of Accountability” {Appendix A}] ⁵ | | | | | | | |

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Step 2: What coverage would you like?

Section 2a: Term Life Insurance Benefit Amount

I am applying for the following term life benefit amount (please choose one option):

☐ [Essential Life]⁶ [\$25,000]⁷ ☐ [Enhanced Life]⁸ [\$50,000]⁹ ☐ [[\$10,000-\$100,000 in \$5,000 increments]¹⁰]¹¹

Section 2b: Replacement of Coverage

Is an agent assisting you? ☐ Yes ☐ No

1. Do you have an existing individual life insurance policy or annuity contract? ☐ Yes ☐ No

2. By applying for this life policy, do you intend to replace or change any life insurance or annuity contract in force with any other company? ☐ Yes ☐ No

Replacement means termination of the policy or contract, discontinuing premium payment, surrendering the policy, forfeiting the policy, assigning the policy to the insurer or making any changes to the existing policy or contract.

If your response to question number “2” is “Yes”, you are not eligible to apply for this coverage.

Step 3: Owner Information (Only complete if other than the proposed insured)

Section 3: Owner Information

| | | | | |
|-------------------------------|---------|-------------------------|-----------------|------|
| Last Name (Legal Name) | | First Name (Legal Name) | | M.I. |
| Home address (not a P.O. Box) | | City | State | ZIP |
| Relationship to Applicant | SSN/TIN | Primary Phone | Secondary Phone | |

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Step 4: Beneficiary Information

| Section [4]: Beneficiary Information | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------|-----------------------------------|
| Primary Beneficiary(ies) First Name, Last Name | Date of Birth (mm/dd/yyyy) | Relationship to You | Benefit % (Total must equal 100%) |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Contingent Beneficiary(ies) First Name, Last Name | Date of Birth (mm/dd/yyyy) | Relationship to You | Benefit % (Total must equal 100%) |
| | | | |
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| | | | |
| Unless otherwise directed, the insurance proceeds shall be divided equally among all persons who are named as primary beneficiary and who survive the insured, but if none survive, equally among all persons who are named as contingent beneficiary and who survive the insured. | | | |
| Change in Beneficiary(ies): I hereby revoke any current designations and change my beneficiary(ies) to those listed herein. I alone am responsible for having read and completed the beneficiary information. | | | |
| Insured Signature | Insured Name (Printed) | Date Signed (mm/dd/yyyy): | |
| [Spousal consent for community property states only (Note: The insurance company is not responsible for the validity of a spouse consent designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA or WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as primary beneficiary for [50%] ¹⁶ or more of your benefit amount. Please have your spouse read the following and sign below: I am aware that my spouse, the proposed insured named above, has designated someone other than me to be the beneficiary of their individual life 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. | | | |
| Spouse Signature | Spouse Name (Printed) | Date Signed (mm/dd/yyyy)] ¹⁷ | |

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Step 5: Health Information

Section 5: Health History Please complete these questions

A. Within the past 5 years, has the proposed insured been hospitalized, diagnosed by a medical professional, received treatment or had treatment recommended, or taken prescription medication for any of the following:

a. Angina, stroke, heart attack, congestive heart failure, heart by-pass surgery, angioplasty, coronary artery stenting, or coronary artery disease?

☐ Yes ☐ No

b. Insulin dependent diabetes, chronic lower lung disease, lupus, Amyotrophic Lateral Sclerosis (ALS), organ transplant, kidney disease, dementia or Alzheimer's?

☐ Yes ☐ No

c. Any form of cancer, Hodgkin's disease, leukemia, lymphoma, multiple myeloma (excluding non-invasive, non-melanoma skin cancer)?

☐ Yes ☐ No

d. Alcoholism or drug or alcohol abuse, cirrhosis or Hepatitis C?

☐ Yes ☐ No

e. Any disorders or diseases of the immune system except those related to Human Immunodeficiency Virus (AIDS virus)?

☐ Yes ☐ No

B. Has the proposed insured been diagnosed with or treated by a member of the medical profession for Human Immunodeficiency Virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

☐ Yes ☐ No

C. Has the proposed insured ever applied for and been rejected for life insurance?

☐ Yes ☐ No

Please review your answers to these questions to be sure that you have answered them fully and truthfully.
[Answering "Yes" to any of these questions may disqualify you from acceptance for coverage.]¹⁸

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Step 6: Please read and sign

Please sign below

Section 6 – Important Legal Information

I understand that:

1. I must send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Anthem Life has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. If my application is denied, my bank account or credit card will not be charged, and if I paid with a check or money order, it will be returned to me.
2. I'm responsible to let Anthem Life know, in a timely manner, of any change that would make me ineligible for coverage.
3. Anthem Life may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge will not enroll me in any Anthem Life automatic debit process and will only occur each time I send a check to Anthem Life. Any resubmissions due to insufficient funds may also occur electronically. All checking transactions will remain secure, and my payment by check means I agree to these terms.
4. I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem Life and myself.
5. I'm applying for individual life coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid.
6. I certify that the Social Security number listed on this application, if provided, is correct.
7. I consent to receive information about my benefits by email or electronically. This may include my policy or evidence of coverage, billing, required notices and helpful or personalized information to get the most out of my plan. I have access to the Internet for the purposes of accepting electronic delivery of the documents and a means by which I can provide an email address. I will make sure that Anthem Life has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time and request a free copy of specific materials by mail. To do either, I will update my communication preferences by going to anthem.com or calling Member Services.
☐ Yes ☐ No
8. I acknowledge that I have read the Important Legal Information section, and I agree to the coverage conditions. I state that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem Life in accepting this application. Any practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I give this authorization for myself if covered by Anthem Life. This application cannot be altered by the applicant after submission to Anthem Life absent the acknowledgement and consent of Anthem Life.

| | |
|-------------------------------------------------------------------|-------------------|
| Applicant (or legal representative) | Date (mm/dd/yyyy) |
| Owner (only required if Owner is other than the proposed insured) | Date (mm/dd/yyyy) |

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[Step 7: Agent Information

If an agent assisted you, please make sure they fill out this section.

| Section 7 Agent (or broker) Certification | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------|-------|-----|--|--|
| I certify to the best of my knowledge, the responses herein are accurate. All fields are required. I further certify that [the applicant does not have an existing individual life insurance policy] ¹⁹ [or if such policy exists,] ²⁰ [that by applying for this coverage, the applicant does not intend to terminate, discontinue premium payments, surrender, forfeit, assign to an insurer or make any changes to an existing individual life insurance policy] ²¹ . | | | | | | |
| Agent/Broker Signature | | | Date | | | |
| Agent Name (Please print clearly) | | | | | | |
| * (A) Writing Agent TIN / SSN (Encrypted TIN is ok) | | * (B) Writing Agent/Agency/General Agency TIN (Encrypted TIN is ok) | | | | |
| Agent Address | | City | State | ZIP | | |
| Agent Phone No. | Agent Fax No. | Agent Email | | | | |
| * Field (A) - Always provide your Writing Agent TIN/SSN. Field (B) - If you are a Direct Agent, with no relationship to an Agency, also enter your Agent TIN/SSN in Field (B). If this policy is sold through an Agency without a General Agency, enter the selling Agency TIN in Field (B); if this policy is sold through a General Agency, enter the General Agency TIN in Field (B).] ²² | | | | | | |

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Here's what's next.

- 1) Can you check a few items? When incorrect, they're the most frequent reasons for delays in enrollment.
 - Your name and address information should be clear and readable
 - You've included your first month's premium payment
 - You signed this form
 - Please make sure you submit all the pages of the application
- 2) All good? Send this to us by mail to [Company Name, Address or by fax to 1 (xxx) xxx-xxxx.]²³
- 3) We'll be in touch in the next few weeks. If you have questions before then, call us at [1 (xxx) xxx-xxxx]²⁴

Thank you!

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[Appendix [A]²⁵: Statement of Accountability

Fill out when applicant cannot complete application.

Statement of Accountability

Note: Translator must be 18 years or older to translate the application on behalf of the applicant.

I, _____, personally read and completed this Individual Application for the applicant named below because:

- ☐ Applicant does not read English
- ☐ Applicant does not speak English
- ☐ Applicant does not write English
- ☐ Applicant is Limited English Proficient
- ☐ Other (explain) _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

Applicant or by: _____

Language interpreted

- ☐ Spanish ☐ Chinese²⁶ ☐ Korean²⁷ ☐ Tagalog²⁸ ☐ Vietnamese²⁹
☐ Other _____³⁰

I also interpreted and fully explained the "Important legal information" and the "Payment Method".

| | |
|-------------------------------------------|-------------------------------------|
| Signature of Translator (required) | Date (mm/dd/yyyy) (required) |
|-------------------------------------------|-------------------------------------|

I confirm that the application was translated on my behalf.

| | |
|------------------------------------------|----------------------------------------------------|
| Signature of Applicant (required) | Date (mm/dd/yyyy) (required)] ³¹ |
|------------------------------------------|----------------------------------------------------|

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Underwritten by: Anthem Life Insurance Company

Please mail this application to the following address:

Anthem Life Insurance Company,
[P.O. Box 12345
Worthington, Ohio 43235]³²

Or

Fax to: [1-xxx-xxx-xxxx]³³

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

PaymentMethodsforIndividualApplication

| | |
|--------------------------|-------------------------------------|
| Applicant's/Member Name: | Applicant's Social Security Number: |
|--------------------------|-------------------------------------|

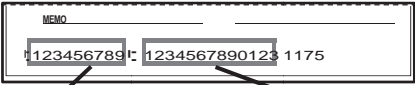
Anthem Life will accept payments made on behalf of applicants/members if the payment is made by the following persons or entities: Indian tribes, tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem Life does not accept premium payments from third parties that are not listed above. Examples of third parties from whom Anthem Life will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer sponsored life insurance plan. **Note: As allowed by law, Anthem Life reserves the right to decline monthly payments from third parties.**

All payments will be debited (taken out of my bank account) or charged to my credit/debit card the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what was presented at time of application because my coverage has not been approved yet. In addition, I understand that my future payments may vary as a result of change in age or change(s) I make once enrolled, including but not limited to, moving my residence, changing coverage and/or changes made by Anthem Life of which I am notified according to my plan/policy. I agree that Anthem Life has the right to debit/charge my bank account/card in the same way as if it were a check that I signed. I agree to pay any service charge that Anthem Life may bill me because the debit/charge was not successful. I understand if my monthly payment increases based on a certain percentage, Anthem Life will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1: Have your first and future monthly payments automatically deducted from your bank account.**

All of your monthly payments will be taken out of the bank account you check below.
Checking account: ☐ Business ☐ Personal
Savings account: ☐ Business ☐ Personal
Enter the requested debit date from your bank account (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.
Write the routing and account numbers that are on your check here: 

I agree that Anthem Life can automatically debit the bank account above each month. I understand monthly payments will be made on the day I've indicated. I agree that Anthem Life can debit my account until I let them know that I no longer want them to do this by giving them a 30-day advance written notice. I agree that should my bank not allow Anthem Life to debit my account for any reason, I will be removed from automatic monthly payments and will be billed by mail.

| | | |
|--------------------------------------------------------|---------------------------------------------------------------|-----------------|
| Authorized signature (as it appears on bank's records) | Printed bank account holder's name (as it appears on account) | Date (MM/DD/YY) |
| X | | |

☐ **Option 2: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below.
Enter the requested charge date for your credit/debit card: (1st to 6th of each month).

I agree that Anthem Life can automatically charge my credit/debit card each month. I understand monthly payments will be made on the day I've indicated. I agree that Anthem Life can charge my account until I let them know that I no longer want them to do this by giving them a 30-day advance written notice. I agree that should any Anthem Life credit/debit card transaction not be honored, I will automatically be removed from automatic monthly payments and will be billed by mail.

Anthem Life accepts ☐ Visa or ☐ MasterCard ☐ [other card]³⁴ (Note to applicant: Please check one.)

| | | |
|----------------------------------------------|----------------------------------------------------|-----------------|
| Card number | Expiration date (MM/YY) | |
| Billing address for this credit/debit card | City | ZIP code |
| Authorized signature (as it appears on card) | Printed card holder's name (as it appears on card) | Date (MM/DD/YY) |
| X | | |

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------|-------------------------------|
| <input type="checkbox"/> Option 3: Have your first [monthly]³⁵ payment automatically deducted or charged to your credit/debit card and receive a bill each [month]³⁶ for your future [monthly]³⁷ payments. Initial Payment: Choose one of the ways below that you would like to pay only your first monthly payment. <input type="checkbox"/> Check (enclose your paper check with application) <input type="checkbox"/> Electronic check (fill out section A below) <input type="checkbox"/> Credit/Debit card (fill out section B below) [Future Billing: Choose a mode for billing and payment frequency (please select one option): <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual] ³⁸ A. Electronic check: Instead of sending us a paper check, you can use an electronic check that allows Anthem Life to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information. | | | |
| Printed account holder name | Routing number | Account number | Amount of first payment \$ |
| B. Credit/Debit card: I allow Anthem Life to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem Life. Anthem Life accepts <input type="checkbox"/> Visa or <input type="checkbox"/> MasterCard <input type="checkbox"/> [Other card] ³⁸ | | | |
| Card number | Expiration date (MM/YY) | | |
| Billing address for this credit/debit card | | City | ZIP code |
| I agree that Anthem Life can debit/charge the bank account/card listed above to make my first monthly payment only. I further agree that Anthem Life will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that this is a one-time payment and that I am responsible for making sure Anthem Life receives my future monthly payments after this first | | | |
| Authorized signature (as it appears on bank account/card) X | Printed bank account/card holder's name (as it appears on account/card) | | Date (MM/DD/YY) |