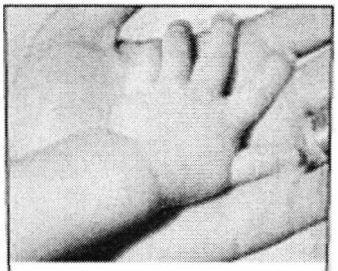

Good news—life insurance coverage is easy to understand. This benefit summary gives a basic outline of life insurance coverage including benefits that can be used now, and much more!

Anthem BlueCross

Your Optional Life Insurance Benefits

Ventura County Community College District

Feel confident in knowing that your family is protected with Anthem Blue Cross' Optional Group Term Life Insurance. Please review your benefit certificate for specific plan details, eligibility definitions, limitations and exclusions.

Eligibility: All eligible employees working 20 or more hours per week

Earnings Definition: Base Earnings

Optional group term life insurance benefit amount

You may purchase coverage in an amount from $10,000 to $500,000 or 5x's annual earnings; whichever is less in increments of $10,000. Your family or beneficiary will get this additional benefit amount if you pass away.

For any amount of Optional Life coverage requested, you will need to complete an Evidence of Insurability (EOI) form and have it approved by Anthem Blue Cross.

Optional employee accidental death and dismemberment insurance benefit amount: Same as Optional Life amount. Optional AD&D coverage is included for all employees who election Optional Life coverage.

Optional accidental Death and Dismemberment Insurance pays a benefit to your beneficiary if your death is caused by an accident. You may also get part of this benefit if an accident results in the loss of sight, a limb, certain fingers or toes, speech, hearing or certain types of paralysis (not able to move part of your body).

Optional life coverage for your family

You may also choose additional life coverage for your spouse and your children:

You may purchase coverage for your spouse: Increments of $5,000 up to $250,000

You may purchase coverage for your children (15 days – age 26 years): Increments of $5,000 up to $10,000

For any amount of Optional Life coverage requested, you will need to complete an Evidence of Insurability (EOI) form and have it approved by Anthem Blue Cross.

Dependents' coverage may not exceed 50% of the employee's benefit amount.

Benefits after age 65

You will still have benefits after age 65, though they will reduce as follows:

35% reduction at age 65; 50% reduction at age 70

All benefits end at retirement.

Living Benefit (accelerated death benefit)

You can ask for up to 75% of your optional life benefits to be paid while you are living, if you are terminally ill with less than 12 months to live. If you take a Living Benefit payment, the amount your beneficiary gets after your death will be reduced by the amount you were paid.

Waiver of premium

We may continue your life insurance coverage until you turn 65 if you become totally disabled and not able to work prior to age 60. You will not pay premiums after the first six months after we approve your waiver of premium claim.

Portability of optional life insurance

If you leave employment for reasons other than retirement or disability, this feature allows you to take your optional life insurance coverage with you by paying the required premiums. Plus, the rates are typically lower than an individual policy.

Conversion

If you leave your job – for any reason – you may be able to change your group life coverage to an individual policy. You must apply for coverage and pay the first month's premium for the individual policy within 31 days of the last day you were employed.

Additional employee optional accidental death and dismemberment insurance benefits

Your optional AD&D coverage also includes extra benefits that also pay for certain losses: *Seat Belt Benefit* if you die in an auto accident while wearing a seatbelt and *Air Bag Benefit* if you die in an auto accident while wearing a seatbelt in a car that has an airbag; *Child Education Benefit* helps pay your eligible child's college costs if you die in an accident; *Repatriation Benefit*, helps pay costs to prepare and transport your body if you die in an accident more than 75 miles from home; *Common Carrier Benefit* if you die in a public transportation accident; *Coma Benefit* if you are in a coma due to an accident.

Resource Advisor

This support program comes with your life coverage to give you and your family private access to work/life resources, at no additional cost to you, including: counseling sessions for qualifying events; identity theft victim recovery services; legal and financial consultations; toll-free, 24/7 phone consultations and referrals from anywhere in the United States; and unlimited access to Resource Advisor online resources at www.resourceadvisorca.anthem.com, program name "ResourceAdvisor". You can also access Resource Advisor benefits by calling (888) 209-7840.

Travel assistance

This program comes with your life coverage to give you access to emergency medical help, travel services and useful tips for your trip if you travel more than 100 miles from home – all at no additional cost to you. To access benefits, visit www.europassistance-usa.com. The username is AnthemBC, the password is 95164. You can also access Travel assistance benefits by calling: US and Canada (866) 295-4890, other locations (call collect) (202) 296-7482.

SpecialOffers@Anthem℠

This program gives you and your family money saving discounts on products and services that promote better health and well-being. To find out more about SpecialOffers@Anthem℠ discounts and benefits, go to anthem.com/specialoffers.

Beneficiary support programs

If you should pass away, we're here to help your beneficiary (the person who gets your life insurance benefit):

- Beneficiaries continue to have access to Resource Advisor services, including all the features described above, plus they get three face-to-face visits with a counselor in the first six months after their loss.
- Beneficiary Companion services help them close accounts and settle important estate matters with one phone call. That way, they can focus on healing.
- Beneficiaries can order copies of *The Healing Book – Facing the Death – and Celebrating the Life – of Someone You Love* for children affected by the loss. This book can really help children at a time when they need it most – and there's no charge for it.
- Your beneficiary can choose to have your life insurance benefits paid through our Access Advantage account. That way the funds can be used right away or when they are needed. Access Advantage accounts earn interest, so important investment decisions can be made later, at a less stressful time.

Cost for optional life benefits

Employee and Spouse optional group term life rates – SPOUSE RATES BASED ON EMPLOYEE'S AGE			
AGE	**Tenthly Rate per $1,000 of coverage**	**AGE**	**Tenthly Rate per $1,000 of coverage**
<25	$0.048	**50-54**	$0.312
25-29	$0.048	**55-59**	$0.504
30-34	$0.060	**60-64**	$0.720
35-39	$0.084	**65-69**	$1.224
40-44	$0.132	**70-74**	$3.984
45-49	$0.204	**75+**	$6.384
Child optional group term life rates – Tenthly Rate per $1,000 of coverage: $0.252 (covers all dependent children)			
Employee Optional AD&D rate – Tenthly Rate per $1,000 of coverage: $0.024			

How to calculate your premium

In the above rate chart, you will see tenthly rates per $1,000 of coverage. Find your age band and note the rate, then complete the information below to find your tenthly premium.

Employee Age: _____

Employee Tenthly Rate per $1,000 of Coverage: _____ (A)

Spouse Tenthly Rate per $1,000 of Coverage: _____ (B)

Child Tenthly Rate per $1,000 of Coverage: _____ (C)

_____ of coverage X _____ (A) / 1,000 = _____ **Tenthly Premium for Employee (D)**

_____ of coverage X _____ (B) / 1,000 = _____ **Tenthly Premium for Spouse (E)**

_____ of coverage X _____ (C) / 1,000 = _____ **Tenthly Premium for Child (F)**

TOTAL TENTHLY PREMIUM (D) + (E) + (F) = _____ (G)

Anthem BlueCross

Ventura County Community College District

Group Number : _____

Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

Name/Address	Date of Birth	Employee ID/SSN
	Division	Date of Hire
	BillClass	SubGroup
	Effective Date	Gender

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. Please complete all grayed sections. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work? Yes ☐ No ☐

Are you retired? Yes ☐ No ☐

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Occupation: _____

Phone: _____

Hours per week working for this employer: _____ **Email Address:** _____

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Optional Life and AD&D

Optional Life allows you to expand and enhance your benefits through convenient payroll deduction. Optional life gives you the opportunity to purchase life insurance coverage for yourself at a fraction of what insurance would cost in the individual market place.

You may elect $10,000 increments not to exceed $500,000 or 5X salary whichever is less. Please select a benefit amount from below or select one from the attached rate matrix. Any benefit election will require an Evidence of Insurability form.

			Other Benefit
Coverage Amount	☐ **$50,000.00**	☐ **$100,000.00**	☐ _____
Tenthly Premium	_____	_____	_____

Reduction Schedule : By 35% at age 65; By 50% at age 70. Benefits terminate at retirement.

Optional Spouse/Domestic Partner Dependent Life

You may elect increments of $5,000 to a maximum of $250,000 not to exceed 50% of the employee benefit amount. You must elect Optional employee life in order to purchase the dependent coverage. Spouse/Domestic Partner amounts elected will require an evidence of insurability form to be completed.

Accept ☐ **Decline** ☐

You may elect $5,000 increments not to exceed $250,000; coverage may not exceed 50% of employee's benefit. You can elect one of the following benefit amounts or select another amount from the rate matrix.

							Other Benefit
Coverage Amount	☐	**$25,000.00**	☐	**$15,000.00**	☐	**$20,000.00**	☐ _____
Tenthly Premium		_____		_____		_____	_____

Reduction Schedule : By 35% at age 65; By 50% at age 70. Benefits terminate at retirement.

Optional Child(ren) Dependent Life

You may elect increments of $5,000 to a maximum of $10,000 not to exceed 50% of the employee benefit amount. You must elect Optional employee life in order to purchase the dependent coverage.

You may elect $5,000 increments not to exceed $10,000; may not exceed 50% of employee's benefit amount. You can elect one of the following benefit amounts.

Accept ☐ **Decline** ☐

Coverage	☐	**$10,000.00**	☐	**$5,000.00**
Amount Tenthly Premium		_____		_____

*Child Coverage from 15 days to 26 years.

BENEFICIARY DESIGNATION

It is important that your beneficiary designation is clear. It is also important that you name a primary beneficiary and contingent beneficiary. If the beneficiary is not related to you by either blood or marriage, please insert the words 'Not Related' in the relationship box.
If you reside in a state with Marital or Community Property Laws, spousal consent is required if your spouse is not listed as a Primary Beneficiary for at least 50%.

Spousal Signature (Consent) : _____

NOTE: Please complete the section below for Employee Coverage ONLY. You "the employee" will always be considered the beneficiary for the Dependent Life Insurance when elected.

EMPLOYEE BENEFICIARY DESIGNATION			In equal shares unless otherwise provided below			
Primary Beneficiary	Last name	First name, M.I.	Social Security # _ _	Relationship to Applicant	Age	%
Primary Beneficiary	Last name	First name, M.I.	Social Security # _ _	Relationship to Applicant	Age	%
			In equal shares unless otherwise provided below			
Contingent Beneficiary	Last name	First name, M.I.	Social Security # _ _	Relationship to Applicant	Age	%
Contingent Beneficiary	Last name	First name, M.I.	Social Security # _ _	Relationship to Applicant	Age	%

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer's plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing 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 and subjects such person to criminal and civil penalties.

Employee Signature_____Date_____/_____/ _____

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

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.

EMPLOYEE OPTIONAL GROUP TERM LIFE AND AD&D PREMIUMS

Tenthly Premiums

Ventura County Community College District

ATTAINED AGE	EMPLOYEE AMOUNTS OF INSURANCE														
	$10,000	*$20,000*	*$30,000*	*$40,000*	*$50,000*	*$60,000*	*$70,000*	*$80,000*	*$90,000*	*$100,000*	*$110,000*	*$120,000*	*$130,000*	*$140,000*	*$150,000*
<25	0.72	1.44	2.16	2.88	3.60	4.32	5.04	5.76	6.48	7.20	7.92	8.64	9.36	10.08	10.80
25 - 29	0.72	1.44	2.16	2.88	3.60	4.32	5.04	5.76	6.48	7.20	7.92	8.64	9.36	10.08	10.80
30 - 34	0.84	1.68	2.52	3.36	4.20	5.04	5.88	6.72	7.56	8.40	9.24	10.08	10.92	11.76	12.60
35 - 39	1.08	2.16	3.24	4.32	5.40	6.48	7.56	8.64	9.72	10.80	11.88	12.96	14.04	15.12	16.20
40 - 44	1.56	3.12	4.68	6.24	7.80	9.36	10.92	12.48	14.04	15.60	17.16	18.72	20.28	21.84	23.40
45 - 49	2.28	4.56	6.84	9.12	11.40	13.68	15.96	18.24	20.52	22.80	25.08	27.36	29.64	31.92	34.20
50 - 54	3.36	6.72	10.08	13.44	16.80	20.16	23.52	26.88	30.24	33.60	36.96	40.32	43.68	47.04	50.40
55 - 59	5.28	10.56	15.84	21.12	26.40	31.68	36.96	42.24	47.52	52.80	58.08	63.36	68.64	73.92	79.20
60 - 64	7.44	14.88	22.32	29.76	37.20	44.64	52.08	59.52	66.96	74.40	81.84	89.28	96.72	104.16	111.60
65 - 69	12.48	24.96	37.44	49.92	62.40	74.88	87.36	99.84	112.32	124.80	137.28	149.76	162.24	174.72	187.20
70 - 74	40.08	80.16	120.24	160.32	200.40	240.48	280.56	320.64	360.72	400.80	440.88	480.96	521.04	561.12	601.20
75+	64.08	128.16	192.24	256.32	320.40	384.48	448.56	512.64	576.72	640.80	704.88	768.96	833.04	897.12	961.20

ATTAINED AGE	EMPLOYEE AMOUNTS OF INSURANCE														
	$160,000	*$170,000*	*$180,000*	*$190,000*	*$200,000*	*$210,000*	*$220,000*	*$230,000*	*$240,000*	*$250,000*	*$260,000*	*$270,000*	*$280,000*	*$290,000*	*$300,000*
<25	11.52	12.24	12.96	13.68	14.40	15.12	15.84	16.56	17.28	18.00	18.72	19.44	20.16	20.88	21.60
25 - 29	11.52	12.24	12.96	13.68	14.40	15.12	15.84	16.56	17.28	18.00	18.72	19.44	20.16	20.88	21.60
30 - 34	13.44	14.28	15.12	15.96	16.80	17.64	18.48	19.32	20.16	21.00	21.84	22.68	23.52	24.36	25.20
35 - 39	17.28	18.36	19.44	20.52	21.60	22.68	23.76	24.84	25.92	27.00	28.08	29.16	30.24	31.32	32.40
40 - 44	24.96	26.52	28.08	29.64	31.20	32.76	34.32	35.88	37.44	39.00	40.56	42.12	43.68	45.24	46.80
45 - 49	36.48	38.76	41.04	43.32	45.60	47.88	50.16	52.44	54.72	57.00	59.28	61.56	63.84	66.12	68.40
50 - 54	53.76	57.12	60.48	63.84	67.20	70.56	73.92	77.28	80.64	84.00	87.36	90.72	94.08	97.44	100.80
55 - 59	84.48	89.76	95.04	100.32	105.60	110.88	116.16	121.44	126.72	132.00	137.28	142.56	147.84	153.12	158.40
60 - 64	119.04	126.48	133.92	141.36	148.80	156.24	163.68	171.12	178.56	186.00	193.44	200.88	208.32	215.76	223.20
65 - 69	199.68	212.16	224.64	237.12	249.60	262.08	274.56	287.04	299.52	312.00	324.48	336.96	349.44	361.92	374.40
70 - 74	641.28	681.36	721.44	761.52	801.60	841.68	881.76	921.84	961.92	1,002.00	1,042.08	1,082.16	1,122.24	1,162.32	1,202.40
75+	1,025.28	1,089.36	1,153.44	1,217.52	1,281.60	1,345.68	1,409.76	1,473.84	1,537.92	1,602.00	1,666.08	1,730.16	1,794.24	1,858.32	1,922.40

ATTAINED AGE	EMPLOYEE AMOUNTS OF INSURANCE														
	$310,000	*$320,000*	*$330,000*	*$340,000*	*$350,000*	*$360,000*	*$370,000*	*$380,000*	*$390,000*	*$400,000*	*$410,000*	*$420,000*	*$430,000*	*$440,000*	*$450,000*
<25	22.32	23.04	23.76	24.48	25.20	25.92	26.64	27.36	28.08	28.80	29.52	30.24	30.96	31.68	32.40
25 - 29	22.32	23.04	23.76	24.48	25.20	25.92	26.64	27.36	28.08	28.80	29.52	30.24	30.96	31.68	32.40
30 - 34	26.04	26.88	27.72	28.56	29.40	30.24	31.08	31.92	32.76	33.60	34.44	35.28	36.12	36.96	37.80
35 - 39	33.48	34.56	35.64	36.72	37.80	38.88	39.96	41.04	42.12	43.20	44.28	45.36	46.44	47.52	48.60
40 - 44	48.36	49.92	51.48	53.04	54.60	56.16	57.72	59.28	60.84	62.40	63.96	65.52	67.08	68.64	70.20
45 - 49	70.68	72.96	75.24	77.52	79.80	82.08	84.36	86.64	88.92	91.20	93.48	95.76	98.04	100.32	102.60
50 - 54	104.16	107.52	110.88	114.24	117.60	120.96	124.32	127.68	131.04	134.40	137.76	141.12	144.48	147.84	151.20
55 - 59	163.68	168.96	174.24	179.52	184.80	190.08	195.36	200.64	205.92	211.20	216.48	221.76	227.04	232.32	237.60
60 - 64	230.64	238.08	245.52	252.96	260.40	267.84	275.28	282.72	290.16	297.60	305.04	312.48	319.92	327.36	334.80
65 - 69	386.88	399.36	411.84	424.32	436.80	449.28	461.76	474.24	486.72	499.20	511.68	524.16	536.64	549.12	561.60
70 - 74	1,242.48	1,282.56	1,322.64	1,362.72	1,402.80	1,442.88	1,482.96	1,523.04	1,563.12	1,603.20	1,643.28	1,683.36	1,723.44	1,763.52	1,803.60
75+	1,986.48	2,050.56	2,114.64	2,178.72	2,242.80	2,306.88	2,370.96	2,435.04	2,499.12	2,563.20	2,627.28	2,691.36	2,755.44	2,819.52	2,883.60

ATTAINED AGE	EMPLOYEE AMOUNTS OF INSURANCE				
	$460,000	*$470,000*	*$480,000*	*$490,000*	*$500,000*
<25	33.12	33.84	34.56	35.28	36.00
25 - 29	33.12	33.84	34.56	35.28	36.00
30 - 34	38.64	39.48	40.32	41.16	42.00
35 - 39	49.68	50.76	51.84	52.92	54.00
40 - 44	71.76	73.32	74.88	76.44	78.00
45 - 49	104.88	107.16	109.44	111.72	114.00
50 - 54	154.56	157.92	161.28	164.64	168.00
55 - 59	242.88	248.16	253.44	258.72	264.00
60 - 64	342.24	349.68	357.12	364.56	372.00
65 - 69	574.08	586.56	599.04	611.52	624.00
70 - 74	1,843.68	1,883.76	1,923.84	1,963.92	2,004.00
75+	2,947.68	3,011.76	3,075.84	3,139.92	3,204.00

Child Coverage*
$.252 per $1,000 -10thly rates

** Child coverage from 15 days to age 26.*

Anthem Blue Cross

SPOUSE OPTIONAL GROUP TERM LIFE PREMIUMS*
Tenthly Premiums
Ventura County Community College District

ATTAINED AGE	SPOUSE AMOUNTS OF INSURANCE														
	$5,000	*$10,000*	*$15,000*	*$20,000*	*$25,000*	*$30,000*	*$35,000*	*$40,000*	*$45,000*	*$50,000*	*$55,000*	*$60,000*	*$65,000*	*$70,000*	*$75,000*
<25	0.24	0.48	0.72	0.96	1.20	1.44	1.68	1.92	2.16	2.40	2.64	2.88	3.12	3.36	3.60
25 - 29	0.24	0.48	0.72	0.96	1.20	1.44	1.68	1.92	2.16	2.40	2.64	2.88	3.12	3.36	3.60
30 - 34	0.30	0.60	0.90	1.20	1.50	1.80	2.10	2.40	2.70	3.00	3.30	3.60	3.90	4.20	4.50
35 - 39	0.42	0.84	1.26	1.68	2.10	2.52	2.94	3.36	3.78	4.20	4.62	5.04	5.46	5.88	6.30
40 - 44	0.66	1.32	1.98	2.64	3.30	3.96	4.62	5.28	5.94	6.60	7.26	7.92	8.58	9.24	9.90
45 - 49	1.02	2.04	3.06	4.08	5.10	6.12	7.14	8.16	9.18	10.20	11.22	12.24	13.26	14.28	15.30
50 - 54	1.56	3.12	4.68	6.24	7.80	9.36	10.92	12.48	14.04	15.60	17.16	18.72	20.28	21.84	23.40
55 - 59	2.52	5.04	7.56	10.08	12.60	15.12	17.64	20.16	22.68	25.20	27.72	30.24	32.76	35.28	37.80
60 - 64	3.60	7.20	10.80	14.40	18.00	21.60	25.20	28.80	32.40	36.00	39.60	43.20	46.80	50.40	54.00
65 - 69	6.12	12.24	18.36	24.48	30.60	36.72	42.84	48.96	55.08	61.20	67.32	73.44	79.56	85.68	91.80
70 - 74	19.92	39.84	59.76	79.68	99.60	119.52	139.44	159.36	179.28	199.20	219.12	239.04	258.96	278.88	298.80
75+	31.92	63.84	95.76	127.68	159.60	191.52	223.44	255.36	287.28	319.20	351.12	383.04	414.96	446.88	478.80

ATTAINED AGE	SPOUSE AMOUNTS OF INSURANCE														
	$80,000	*$85,000*	*$90,000*	*$95,000*	*$100,000*	*$105,000*	*$110,000*	*$115,000*	*$120,000*	*$125,000*	*$130,000*	*$135,000*	*$140,000*	*$145,000*	*$150,000*
<25	3.84	4.08	4.32	4.56	4.80	5.04	5.28	5.52	5.76	6.00	6.24	6.48	6.72	6.96	7.20
25 - 29	3.84	4.08	4.32	4.56	4.80	5.04	5.28	5.52	5.76	6.00	6.24	6.48	6.72	6.96	7.20
30 - 34	4.80	5.10	5.40	5.70	6.00	6.30	6.60	6.90	7.20	7.50	7.80	8.10	8.40	8.70	9.00
35 - 39	6.72	7.14	7.56	7.98	8.40	8.82	9.24	9.66	10.08	10.50	10.92	11.34	11.76	12.18	12.60
40 - 44	10.56	11.22	11.88	12.54	13.20	13.86	14.52	15.18	15.84	16.50	17.16	17.82	18.48	19.14	19.80
45 - 49	16.32	17.34	18.36	19.38	20.40	21.42	22.44	23.46	24.48	25.50	26.52	27.54	28.56	29.58	30.60
50 - 54	24.96	26.52	28.08	29.64	31.20	32.76	34.32	35.88	37.44	39.00	40.56	42.12	43.68	45.24	46.80
55 - 59	40.32	42.84	45.36	47.88	50.40	52.92	55.44	57.96	60.48	63.00	65.52	68.04	70.56	73.08	75.60
60 - 64	57.60	61.20	64.80	68.40	72.00	75.60	79.20	82.80	86.40	90.00	93.60	97.20	100.80	104.40	108.00
65 - 69	97.92	104.04	110.16	116.28	122.40	128.52	134.64	140.76	146.88	153.00	159.12	165.24	171.36	177.48	183.60
70 - 74	318.72	338.64	358.56	378.48	398.40	418.32	438.24	458.16	478.08	498.00	517.92	537.84	557.76	577.68	597.60
75+	510.72	542.64	574.56	606.48	638.40	670.32	702.24	734.16	766.08	798.00	829.92	861.84	893.76	925.68	957.60

ATTAINED AGE	SPOUSE AMOUNTS OF INSURANCE														
	$155,000	*$160,000*	*$165,000*	*$170,000*	*$175,000*	*$180,000*	*$185,000*	*$190,000*	*$195,000*	*$200,000*	*$205,000*	*$210,000*	*$215,000*	*$220,000*	*$225,000*
<25	7.44	7.68	7.92	8.16	8.40	8.64	8.88	9.12	9.36	9.60	9.84	10.08	10.32	10.56	10.80
25 - 29	7.44	7.68	7.92	8.16	8.40	8.64	8.88	9.12	9.36	9.60	9.84	10.08	10.32	10.56	10.80
30 - 34	9.30	9.60	9.90	10.20	10.50	10.80	11.10	11.40	11.70	12.00	12.30	12.60	12.90	13.20	13.50
35 - 39	13.02	13.44	13.86	14.28	14.70	15.12	15.54	15.96	16.38	16.80	17.22	17.64	18.06	18.48	18.90
40 - 44	20.46	21.12	21.78	22.44	23.10	23.76	24.42	25.08	25.74	26.40	27.06	27.72	28.38	29.04	29.70
45 - 49	31.62	32.64	33.66	34.68	35.70	36.72	37.74	38.76	39.78	40.80	41.82	42.84	43.86	44.88	45.90
50 - 54	48.36	49.92	51.48	53.04	54.60	56.16	57.72	59.28	60.84	62.40	63.96	65.52	67.08	68.64	70.20
55 - 59	78.12	80.64	83.16	85.68	88.20	90.72	93.24	95.76	98.28	100.80	103.32	105.84	108.36	110.88	113.40
60 - 64	111.60	115.20	118.80	122.40	126.00	129.60	133.20	136.80	140.40	144.00	147.60	151.20	154.80	158.40	162.00
65 - 69	189.72	195.84	201.96	208.08	214.20	220.32	226.44	232.56	238.68	244.80	250.92	257.04	263.16	269.28	275.40
70 - 74	617.52	637.44	657.36	677.28	697.20	717.12	737.04	756.96	776.88	796.80	816.72	836.64	856.56	876.48	896.40
75+	989.52	1,021.44	1,053.36	1,085.28	1,117.20	1,149.12	1,181.04	1,212.96	1,244.88	1,276.80	1,308.72	1,340.64	1,372.56	1,404.48	1,436.40

ATTAINED AGE	SPOUSE AMOUNTS OF INSURANCE				
	$230,000	*$235,000*	*$240,000*	*$245,000*	*$250,000*
<25	11.04	11.28	11.52	11.76	12.00
25 - 29	11.04	11.28	11.52	11.76	12.00
30 - 34	13.80	14.10	14.40	14.70	15.00
35 - 39	19.32	19.74	20.16	20.58	21.00
40 - 44	30.36	31.02	31.68	32.34	33.00
45 - 49	46.92	47.94	48.96	49.98	51.00
50 - 54	71.76	73.32	74.88	76.44	78.00
55 - 59	115.92	118.44	120.96	123.48	126.00
60 - 64	165.60	169.20	172.80	176.40	180.00
65 - 69	281.52	287.64	293.76	299.88	306.00
70 - 74	916.32	936.24	956.16	976.08	996.00
75+	1,468.32	1,500.24	1,532.16	1,564.08	1,596.00

** Rates based on employee's age*

Child Coverage*
$.252 per $1,000 10thly rates

** Child coverage from 15 days to age 26.*

California Insurability Information Request

Please keep a copy of this form/notice for your records

Group no.

Medical Evidence Underwriting Unit
LifeDisUW_MEU@anthem.com

Evidence required because of:
☐ Over guaranteed issue amount ☐ Late entrant ☐ Change of benefits

This evidence is provided for:
☐ An effective date under a new group ☐ A post group effective date addition

SECTION 1: GENERAL INFORMATION

Last name	First name	M.I.	Date of birth (MM/DD/YYYY)

Social Security no.	Work phone no.	Home phone no.	Email address

Employee street address	City	State	ZIP code	State of birth	Height	Weight

Request amount $	Name of employer	Employer address

SECTION 2: DEPENDENT INFORMATION — Complete for all dependents (if any) to be covered under this program.

Last name, first name, M.I.	Sex	Date of birth (MM/DD/YYYY)	State of birth	Social Security no.	Relationship	Height	Weight	Dependent request amount
	☐ M ☐ F				Spouse			
	☐ M ☐ F							
	☐ M ☐ F							
	☐ M ☐ F							

SECTION 3: MEDICAL AND ACTIVITIES QUESTIONNAIRE

Complete the following medical questions for all persons to be covered: For the purpose of the following questions, the term "Medical or Social Practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program.

1. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, who? _____
   Expected due date: ____/____/____ (MM/DD/YYYY)
2. Have you or any of your dependents smoked or used tobacco in the last five years? ☐ Yes ☐ No
   If yes, who? _____
   Type: _____
   Quit date (if applicable): ____/____/____ (MM/DD/YYYY)
3. In the past five years, have you or any of your dependents ever:
   a. Had high blood pressure or high cholesterol? ☐ Yes ☐ No
      If yes, who? _____
      Last three readings: _____
   b. Had heart disease, cancer, diabetes, arthritis, or asthma? ☐ Yes ☐ No
   c. Had counseling by a Medical or Social Practitioner for an emotional, mental or nervous condition? ☐ Yes ☐ No
   d. Been treated for alcohol or chemical dependency, or been convicted for driving while intoxicated? ☐ Yes ☐ No
4. Have you or any of your dependents ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
5. In the past three years have you or any of your dependents been prescribed medication? ☐ Yes ☐ No
6. In the past five years have you or any of your dependents had an inpatient admission and/or outpatient surgery? ☐ Yes ☐ No
7. During the past three years, have you or any of your dependents sought medical treatment, or been advised by a Medical or Social Practitioner to seek treatment for any condition not indicated by the answers to the preceding six questions? ☐ Yes ☐ No
8. Have you or any of your dependents ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance? ☐ Yes ☐ No
   If yes, name of person, date and reason: _____
9. In the past three years, have you or any of your dependents been engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? ☐ Yes ☐ No
   Please list: _____

Important notice: No person, including an employee or agent of Anthem Blue Cross Life and Health Insurance Company has the authority to change or omit any of these medical questions.

Si usted necesita ayuda un Espanol para entender este documento, comuniquese con el adminstrador de su grupo.

SECTION 3: MEDICAL AND ACTIVITIES QUESTIONNAIRE (continued)

Explain any "Yes" answers below. If additional space is necessary, attach a separate page including your signature and date.

Question no.	Name of individual	Name of illness or injury	Dates of treatment	Any remaining effects	Name of medication and dosage	Name and address of physician/hospital

SECTION 4: NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 1-866-692-6901.

SECTION 5: AGREEMENT AND AUTHORIZATION

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Blue Cross Life and Health Insurance Company (Anthem), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to ARC or AIDS (excluding disclosure of HIV testing or HIV status), sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem may collect personal information about me and for any dependents listed herein, from outside sources, 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. I also understand that I have a right to see and correct personal information that Anthem collects about me and for any dependents listed herein, and that I may receive a more detailed description of my rights under this law by writing to Anthem.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
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 understand that Anthem reserves the right to accept or decline the application and that no right whatsoever is created by this information request. I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this information request are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in reviewing the application for insurance. 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 information request may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this information request form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem. A photocopy is as valid as the original.

I give this authorization for myself and on behalf of my eligible dependents if covered by the plan, including my Spouse/Domestic Partner unless he/she signs below. I am acting as their agent and representative. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Applicant signature	Date (MM/DD/YYYY)
X	
Spouse/Domestic Partner signature (If to be covered)	Date (MM/DD/YYYY)
X	

This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: **Anthem, P.O. Box 4510 Woodland Hills, CA 91365**. Such revocation must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

REFUSAL OF AUTHORIZATION – I refuse authorization to disclose health care information. I understand that such refusal may result in denial of coverage or denial of a claim.

Applicant signature	Date (MM/DD/YYYY)
X	
Spouse/Domestic Partner signature (If to be covered)	Date (MM/DD/YYYY)
X	

Fraud Warning: For your protection California law requires the following statement to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Reset Form Save and Print