



Participating Unit Page (Employer Application)

1. Client's Name: _____
2. Requested Effective Date: _____ ISMA Membership Confirmed? Yes No
3. Client's Physical Address: _____

4. Phone Number: _____ Fax Number: _____
5. Management Contact: _____ Email: _____

6. All employees are eligible for MEDICAL/DENTAL insurance if they work a minimum of _____ hours per week. (Lowest= 20)
All employees are eligible for TERM LIFE insurance if they work a minimum of _____ hours per week. (Lowest= 20)
Every employee working the minimum hours per week stated above must complete an Application; those waiving coverage need complete only sections 1, 2, 5, and 12 (and 4, 7 and 11 if the term life benefit is provided to ALL full-time employees).

7. 1 Total eligible employees working minimum hours/week (see item 6, above)	
2 Less: Number of employees waiving coverage because covered by spouse	-
3 Net eligible employees	
4 Less: Number of employees waiving coverage and not covered by spouse	-
5 Number of employees enrolling (This number must be 75% or more of line 3, above)	

8. Name of Previous Health and/or Life Carrier/Plan Administrator: _____ No previous carrier
9. Employer contribution toward premiums: MEDICAL/DENTAL: _____ % Employee _____ % Dependent
(Basic Term Life and Dependent Life are non-contributory) TERM LIFE: 100 % Employee 100 % Dependent
10. Probationary Period for New Employees; coverage begins first day of month following end of this period:
MEDICAL/DENTAL: Physicians: 0 days Employees: 30 days 60 days 90 days 0 days
TERM LIFE: Physicians: 0 days Employees: 30 days 60 days 90 days 0 days
11. Waive Probationary Period for all employees recently hired before the effective date of your group plan? Yes No
12. Basic Term Life and AD&D Benefit provided to: All full-time staff Only those taking medical coverage

Please attach 1) copy of most recent billing statement from previous carrier (if applicable), and 2) Tax and Wage statement.

BENEFITS	Physicians check one: <input type="checkbox"/> All plans are available OR <input type="checkbox"/> standard Medical & Dental option below:	Employee
Medical	Plan Name: _____	Plan Name: _____
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Basic Term Life & AD&D	Benefit Amount: \$ _____	Benefit Amount: \$ _____
Dependent Life	Benefit Amount: \$5,000 on each eligible dependent (provided at no charge if Basic Term Life & AD&D is purchased)	Benefit Amount: \$5,000 on each eligible dependent (provided at no charge if Basic Term Life & AD&D is purchased)

Signatures below illustrate an understanding that the ISMA Plan is being offered based upon information provided to Anthem Blue Cross Blue Shield/Anthem Life. Group rates quoted are valid for 10, 11 or 12 months based on enrollment month and will be adjusted, if necessary, based upon the results of the ISMA Plan renewal which occurs each year. Anthem reserves the right to re-rate the group if the number of employees enrolling listed on this form changes by more than 10% within 31 days after the effective date. **The Executive's signature below confirms the acceptance of all information and coverage you have selected.**

Executive name typed/printed _____ Agent's name typed/printed _____

Executive signature (Sign after underwriting) _____ Agent Signature (Sign before underwriting) _____

Date: _____ Date: _____ CSR: _____

UNDERWRITING ACTION

Effective Date: _____ Risk Class: _____ Acct #: _____

Date of Underwriting Action: _____ Underwriter's Initials: _____

AGENT: Please initial below to confirm group's acceptance of final offer then fax this form to Lola Smith at 317-287-8711 within ten (10) business days of the Date of Underwriting Action. Please note that this confirmation finalizes Benefits specified above.

Agent's Initials: _____