# Participating Unit Page (Employer Application)

1. **Client's Name:** ____________________
2. **Requested Effective Date:** ____________ **ISMA Membership Confirmed?** ___Yes ___No
3. **Client's 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 A, E, and H (and F 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
   TERM LIFE: _______% Employee _______% Dependent

10. Probationary Period for New Employees (physicians excluded); coverage begins first day of month following end of this period:
    MEDICAL/DENTAL: ___30 days ___60 days ___90 days ___0 days
    TERM LIFE: ___30 days ___60 days ___90 days ___0 days

11. Waive Probationary Period for employees applying with this Participating Unit Page? ___Yes ___No

12. Term Life 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: ☐All plans are available OR ☐ standard Medical & Dental option below: | **Employee** |
|---|---|---|---|
| **Medical** | Plan Name | | |
| **Dental** | | ____Yes ____No | ____Yes ____No |
| **Term Life** | Amount | $ | $ |

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: ________

Form updated 08/30/2006