LINDSEY WILSON COLLEGE
ANTHEM HEALTH INSURANCE ELECTION FORM
FOR PLAN YEAR 2024

I hereby elect the following health insurance plan for the 2024 plan year:

☐	Single Core Plan MO	$180.00
☐	Single Buy Up Plan MO	$240.00
☐	Employee & Spouse Core Plan MO	$995.00
☐	Employee & Spouse Buy Up Plan MO	$1,147.00
☐	Employee & Children Core Plan MO	$885.00
☐	Employee & Children Buy Up Plan MO	$1,037.00
☐	Family Core Plan MO	$1,007.00
☐	Family Buy Up Plan MO	$1,159.00
☐	Dual Employee Family Core Plan MO	$593.77
☐	Dual Employee Family Buy Up Plan MO	$745.77

☐	Single Core Plan BW	$90.00
☐	Single Buy Up Plan BW	$120.00
☐	Employee & Spouse Core Plan BW	$497.50
☐	Employee & Spouse Buy Up Plan BW	$573.50
☐	Employee & Children Core Plan BW	$442.50
☐	Employee & Children Buy Up Plan BW	$518.50
☐	Family Core Plan BW	$503.50
☐	Family Buy Up Plan BW	$579.50
☐	Dual Employee Family Core Plan BW	$296.89
☐	Dual Employee Family Buy Up Plan BW	$372.89

☐ I waive participation in the 2024 health insurance plan year.

_____ _____

Print Name Employee ID#

_____ _____

Signature Date

GROUP HEALTH PLANS - EMPLOYEE APPLICATION/WAIVER
LINDSEY WILSON COLLEGE

❑ **NEW ENROLLMENT** ❑**CHANGE ENROLLMENT**

A. EMPLOYEE INFORMATION

LAST NAME | FIRST NAME | MI

PARTICIPANT SSN: ___ - ___ - ____ PARTICIPANT DOB: __ / __ / __

ADDRESS | CITY | STATE

ZIP CODE

PLAN TYPE: ☐ CORE ☐ BUY-UP

GENDER: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE

HIRE DATE: __ / __ / __ Effective Date: _____

Termination Date: _____

B. COVERAGE YOU ARE REQUESTING

☐ EMPLOYEE ONLY ☐ EMPLOYEE & FAMILY

IF ENROLLMENT CHANGE PROVIDE QUALIFYING EVENT: _____

C. FAMILY INFORMATION - ENROLLMENT

SPOUSE: LAST NAME | FIRST NAME | MI

SPOUSE SSN: ___ - ___ - ____ SPOUSE DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

Are you or any of your Dependents covered by **Medicare**? ☐ Yes ☐ No If yes, complete the information on the right	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ___/___/_____ B. ___/___/____ C. ___/___/____ D. ___/___/____	A. _____ B. _____ C. _____ D. _____
	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ___/___/_____ B. ___/___/____ C. ___/___/____ D. ___/___/____	A. _____ B. _____ C. _____ D. _____

D. PRIOR MEDICAL COVERAGE

1. ARE YOU OR ANY OF YOUR DEPENDENTS INSURED THROUGH ANY OTHER HEALTH INSURANCE PLAN WHILE COVERED UNDER THIS PLAN? ❑ **YES** ❑ **NO** **IF YES**, PLEASE COMPLETE THE FOLLOWING REQUIREMENTS:

2. HEALTH INSURANCE COMPANY		TELEPHONE NO.	
POLICY OR CERTIFICATE NO.		EFFECTIVE DATE	
COVERAGE TYPE	❑ INDIVIDUAL ❑ EMPLOYER SPONSORED	TERMINATION DATE	
LIST ALL COVERED MEMBERS		POLICY HOLDER NAME	

Premium Payment: I authorize my employer to deduct the requested premium contribution from my earnings.

Authorization to Release Information: I hereby authorize any physician or medical practitioner, hospital, or other organization, institution or person that has any medical records or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to ARC Administrators or its authorized Administrator or legal representative (including medical review specialists). Any information obtained will not be released by the insurance company except to persons or organizations performing business or legal services in connection with my application or claim, including but not limited to pre-certification of hospital admissions, Continued Stay Review, On-Site Concurrent Review or as may be otherwise lawfully required or as I further authorize. A photocopy of this authorization shall be valid as the original and is valid for thirty (30) months from the date shown below.

U.S. Resident: I understand that the coverage under this plan is available for United States Residents and benefits are not payable for medical expenses outside of the United States except while traveling.

My Answers Are True and Correct: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all the questions asked. With the exception of health related factors, I understand that my intentional material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my dependents, if any. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or (c) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

❑ **WAIVER OF COVERAGE.** This is to certify that I have been given an opportunity to insure myself and/or my eligible dependents and I have DECLINED such coverage. I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and my dependents in this plan, provided that I request enrollment within thirty-one (31) days of my other coverage ending. In addition, if I have a new dependent as a result of marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within thirty-one (31) days after the marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption. If I choose to enroll myself or my dependents, at a later date, for a reason other than the special reasons stated herein, I understand that I and/or my dependents may not enroll until my employer's next enrollment period.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to civil and criminal penalties.

E. SIGNATURE

Phone Number: _____ Email Address: _____

_____ Date_____

Signature of Employee and Parent if Applicant is under the age eighteen (18) years

COORDINATION OF BENEFITS QUESTIONNAIRE

NAME	MEMBER PLAN NAME	MEMBER ID NUMBER
MAILING ADDRESS		
CITY	**STATE**	**ZIP CODE**

THIS FORM MUST BE COMPLETED ANNUALLY

YOUR HEALTH BENEFIT PLAN CONTAINS A COORDINATION OF BENEFITS (COB) PROVISION. THIS PROVISION COORDINATES THE BENEFITS YOU OR YOUR DEPENDENTS RECEIVE BY DETERMINING WHICH OF TWO OR MORE BENEFIT PLANS HAS THE PRIMARY RESPONSIBILITY OF PROCESSING AND PAYING A CLAIM AND THE EXTENT TO WHICH OTHER PLANS WILL CONTRIBUTE TOWARD THE COST OF A CLAIM.

TO PROCESS YOUR CLAIMS CORRECTLY WE REQUIRE THE INFORMATION REQUESTED AND APPRECIATE YOUR PROMPT AND ACCURATE REPLY. PLEASE RETURN THIS COMPLETED FORM TO:

MAIL	EMAIL	SECURE FAX
ARC ADMINISTRATORS P.O. BOX 12290 LEXINGTON, KENTUCKY 40582	info@arcsvs.com	(859) 243-0381

IF YOU HAVE ANY QUESTIONS REGARDING THIS QUESTIONNAIRE, COORDINATION OF BENEFITS OR IF THE INFORMATION BELOW CHANGES, PLEASE CONTACT ARC ADMINISTRATORS AT (855) 981-2583.

IN ADDITION TO THIS MEDICAL COVERAGE ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER HEALTH PLAN?

☐ **NO** PLEASE SKIP THE REMAINDER OF QUESTIONS; SIGN, DATE AND PROMPTLY RETURN THIS FORM

☐ **YES** PLEASE COMPLETE THE ENTIRE FORM; SIGN, DATE AND PROMPTLY RETURN THIS FORM

COORDINATION OF BENEFITS QUESTIONNAIRE

NAME	MEMBER PLAN NAME	MEMBER ID NUMBER

ALL INFORMATION IS REQUIRED

PLEASE INCLUDE A COPY OF YOUR ID CARD (FRONT & BACK) FOR OTHER COVERAGE

OTHER CARRIER NAME	OTHER CARRIER MAILING ADDRESS	OTHER CARRIER PHONE NUMBER
POLICY HOLDER NAME	**POLICY HOLDER DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
GROUP NUMBER	**MEMBER NUMBER**	**COVERAGE TYPE**
		MEDICAL ☐ DENTAL ☐ VISION ☐ PHARMACY ☐
EFFECTIVE DATE OF COVERAGE	**TERMINATION DATE OF COVERAGE**	**IS COVERAGE**
______-_______-_______	______-_______-_______	COBRA ☐ RETIREE ☐ MEDICARE ☐ MEDICAID ☐
WHO IS COVERED	**IS COVERAGE COURT ORDERED**	**IS MEDICARE COVERAGE DUE TO**
YOUR SPOUSE ☐ YOUR CHILDREN ☐	YES (PROVIDE DOCUMENTATION) ☐ NO ☐	DISABILITY ☐ AGE ☐ ESRD ☐
SPOUSE NAME (IF COVERED)	**SPOUSE DATE OF BIRTH**	**IS SPOUSE POLICY HOLDER**
	______-_______-_______	YES ☐ NO ☐
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	

IF MEDICARE COVERAGE DUE TO END STAGE RENAL DISEASE (ESRD) PLEASE PROVIDE THE FOLLOWING		
DIALYSIS START DATE	**WHERE DO YOU RECEIVE DIALYSIS**	**IF HOME TRAINING START DATE**
_____-_____-_____	HOME ☐ DIALYSIS CENTER ☐	_____-_____-_____
DATE OF KIDNEY TRANSPLANT	**WAS TRANSPLANT SUCCESSFUL**	**DATE YOU RESUMED DIALYSIS**
_____-_____-_____	YES ☐ NO ☐	_____-_____-_____
WAS THERE A SECOND TRANSPLANT	**WAS SECOND TRANSPLANT SUCCESSFUL**	**DATE YOU RESUMED DIALYSIS**
YES ☐ NO ☐	YES ☐ NO ☐	_____-_____-_____

MEDICARE ADVANTAGE COVERAGE

IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE COVERED BY A MEDICARE ADVANTAGE PLAN THIS MUST BE DISCLOSED BECAUSE YOUR ENROLLMENT IN THIS HEALTH PLAN MAY RESULT IN YOU NO LONGER BEING ENROLLED IN THE MEDICARE ADVANTAGE PLAN. THESE PLANS ARE OFTEN PROVIDED BY EMPLOYERS IN CONJUNCTION WITH RETIREMENT BENEFITS.

A MEDICARE ADVANTAGE PLAN IS A HEALTH INSURANCE PROGRAM THAT SERVES AS A SUBSTIUTE FOR "ORIGINAL MEDICARE" PARTS A AND B COVERAGE. THESE TRADITIONAL MEDICARE BENEFITS ARE PROVIDED BY A COMMERCIAL INSURANCE COMPANY BUT ALSO INCLUDE BENEFITS FOR PRESECRIPTION DRUGS, AND OFTEN INCLUDE OFFICE VISIT COPAYMENTS AND OTHER BENEFITS COMMON TO AN INSURANCE PLAN. THESE BENEFITS ARE NOT TYPICALLY PROVIDED BY MEDICARE PARTS A AND B.

MEDICARE ADVANTAGE CAN INCLUDE PRESCRIPTION DRUG COVERAGE AS PART OF THE PLAN AND IS SUBSIDIZED BY THE CENTER FOR MEDICARE SERVICES (CMS).

IF ANYONE IS COVERED BY A MEDICARE ADVANTAGE PLAN IS COVERED ON THIS PLAN PLEASE COMPLETE		
POLICY HOLDER NAME	**EFFECTIVE DATE**	**MEDICARE ADVANTAGE ID NUMBER**
	_____-_____-_____	
POLICY HOLDER NAME	**EFFECTIVE DATE**	**MEDICARE ADVANTAGE ID NUMBER**
	_____-_____-_____	

SIGNATURE: _____

DATE: _____-_____-_____

HIPAA PROTECTED HEALTH INFORMATION RELEASE FORM

NAME	MEMBER PLAN NAME	MEMBER ID NUMBER
MAILING ADDRESS		
CITY	**STATE**	**ZIP CODE**

THIS AUTHORIZATION SHALL REMAIN IN EFFECT THROUGHOUT YOUR ENROLLMENT

I HEREBY AUTHORIZE ARC ADMINISTRATORS, ITS AGENTS, SUBSIDIARIES AND AFFILIATES TO DISCLOSE MY MEDICAL, CLAIM, CLINICAL AND BENEFIT RECORDS INCLUDING MY PROTECTED HEATLH INFORMATION (PHI) AS INDICATED BELOW TO THE PERSONS OR ENTITIES SPECIFIED ON THIS FORM.

TO PROCESS YOUR REQUEST CORRECTLY WE REQUIRE THAT THIS FORM BE COMPLETED. PLEASE RETURN THIS COMPLETED FORM TO:

MAIL	**EMAIL**	**SECURE FAX**
ARC ADMINISTRATORS P.O. BOX 12290 LEXINGTON, KENTUCKY 40582	info@arcsvs.com	(859) 243-0381

IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM, HIPAA RELEASE AUTHORIZATION OR IF THE INFORMATION BELOW CHANGES, PLEASE CONTACT ARC ADMINISTRATORS AT (855) 981-2583.

UNLESS SPECIFICALLY INDICATED DIFFERENTLY BELOW I HEREBY AUTHORIZE THE FULL RELEASE OF MY MEDICAL, CLAIM, CLINICAL AND BENEFIT RECORDS INCLUDING MY PROTECTED HEALTH INFORMATION (PHI) AND ACKNOWLEDGE THAT THIS INFORMATION MAY BE VIEWED AND OBTAINED THROUGH ONLINE SYSTEMS AS WELL AS DIRECT CONVERSATION. I UNDERSTAND THAT THESE RECORDS MAY CONTAIN INFORMATION CREATED BY PERSONS OR ENTITIES INCLUDING HEALTHCARE PROVIDERS.

I FURTHER UNDERSTAND THAT THESE RECORDS MAY CONTAIN DIAGNOSIS INFORMATION AND/OR TREATMENT INFORMATION FOR ALCOHOLISM, DRUG ABUSE OR DEPENDENCY, MENTAL ILLNESS, INFECTIOUS DISEASES INCLUDING HIV OR AIDS. IN ADDITION, GENETIC TESTING INFORMATION MAY ALSO BE INCLUDED.

HIPAA PROTECTED HEALTH INFORMATION RELEASE FORM

NAME	MEMBER PLAN NAME	MEMBER ID NUMBER

IF YOU WANT TO SPECIFICALLY LIMIT OR RESTRICT THE INFORMATION, DATES OR MANNER IN WHICH THIS INFORMATION IS TO BE DISCLOSED PLEASE INDICATE THOSE LIMITATIONS BELOW.

AUTHORIZED RECIPIENTS

NAME	RELATIONSHIP	EXPIRATION DATE
		_____-_____-_____
RESTRICTIONS ON AUTHORIZATION		
NAME	**RELATIONSHIP**	**EXPIRATION DATE**
		_____-_____-_____
RESTRICTIONS ON AUTHORIZATION		
NAME	**RELATIONSHIP**	**EXPIRATION DATE**
		_____-_____-_____
RESTRICTIONS ON AUTHORIZATION		
NAME	**RELATIONSHIP**	**EXPIRATION DATE**
		_____-_____-_____
RESTRICTIONS ON AUTHORIZATION		

AUTHORIZATION

SIGNATURE: _____

DATE: _____-_____-_____

Life Insurance
Beneficiary Designation Form

Anthem® Life

THE EMPLOYER **MUST** KEEP THIS FORM ON FILE.

Name of employer/group (if applicable)	Policy/certification no.
Name of insured	Social security no.
Name of policyowner (if different)	Social security no.

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%.

PRIMARY BENEFICIARY(IES): Person or persons who will receive the life insurance proceeds upon your death.

Name	Date of birth	Social security no.	
Address		Relationship to insured	% to be paid to beneficiary
Name	Date of birth	Social security no.	
Address		Relationship to insured	% to be paid to beneficiary
Name	Date of birth	Social security no.	
Address		Relationship to insured	% to be paid to beneficiary

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, proceeds will be paid to the Contingent beneficiary(ies) listed below. Space is provided at the bottom of the page if you wish to name additional Primary or Contingent beneficiaries.

CONTINGENT BENEFICIARY(IES): Person or persons who will receive the life insurance proceeds if there is no surviving primary beneficiary.

Name	Date of birth	Social security no.	
Address		Relationship to insured	% to be paid to beneficiary
Name	Date of birth	Social security no.	
Address		Relationship to insured	% to be paid to beneficiary
Name	Date of birth	Social security no.	
Address		Relationship to insured	% to be paid to beneficiary

Signature of insured or policyowner (2 officers' signatures, with title, are required if corporate owned) **X**	Date signed (MM/DD/YYYY)
Signature of spouse (if not designated as primary beneficiary and residence is in community property state) **X**	Date signed (MM/DD/YYYY)

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.

Life Insurance
Beneficiary Designation Form - continued

THE EMPLOYER **MUST** KEEP THIS FORM ON FILE.

BENEFICIARY DESIGNATIONS

DEFINITIONS:
The purpose of designating beneficiaries for this policy is to instruct Anthem Life Insurance Company (Anthem Life) exactly how you wish the proceeds of your policy/certificate to be paid upon your death. Therefore, please take a moment to read the examples below:

PRIMARY BENEFICIARY:
Person or persons to receive the Life Insurance proceeds upon the death of the Insured. If multiple Primary Beneficiaries are listed, death benefits are divided equally among all the living Primary Beneficiaries, unless otherwise stated.

CONTINGENT BENEFICIARY:
Person or persons to receive the Life Insurance proceeds when the Primary Beneficiary(ies) dies before the Insured. If multiple Contingent Beneficiaries are listed, death benefits are divided equally among all the living Contingent Beneficiaries, unless otherwise stated.

EXAMPLES OF CORRECT BENEFICIARY DESIGNATIONS:

Joe and Jane Smith – Father and Mother
William E. Brown – Spouse
George Jones – Friend
Donald C. White, Jane E. Smith, and Richard E. Beck – Children

If you choose the estate or a trust as beneficiary, see the following example beneficiary designation:
Insured's Estate: John Q. Smith – trustee under the Mary R. Smith Trust dated 01/02/2006.

Full given names of each beneficiary must be clearly stated.

NOTE: INSUREDS OF GROUP INSURANCE MAY ***NOT*** DESIGNATE THEIR EMPLOYER AS BENEFICIARY. Employees should make a copy to keep for their personal record. Employers need to keep original on file. For All Voluntary benefits, a legible copy ***must*** be sent to Anthem Life.

ADDITIONAL BENEFICIARY(IES)

PRIMARY

Name	Date of birth	Social security no.
Address	Relationship to insured	% to be paid to beneficiary
Name	Date of birth	Social security no.
Address	Relationship to insured	% to be paid to beneficiary
Name	Date of birth	Social security no.
Address	Relationship to insured	% to be paid to beneficiary

CONTINGENT

Name	Date of birth	Social security no.
Address	Relationship to insured	% to be paid to beneficiary
Name	Date of birth	Social security no.
Address	Relationship to insured	% to be paid to beneficiary

Welcome to Anthem Life! 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 Life

Your Life Insurance Benefits

Lindsey Wilson College - #AL00004927

Benefits effective 1/1/2018

Eligibility: All active full-time permanent employees covered by the employer medical plan at Lindsey Wilson College

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

Group term life insurance benefit amount: $15,000

Your family or beneficiary will get the benefit amount if you pass away.

Accidental death and dismemberment insurance benefit amount: $15,000

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).

Benefits after age 65

You will still have benefits after you turn 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 group term 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.

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 accidental death and dismemberment insurance benefits

Your 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.resourceadvisor.anthem.com, program name "anthemresourceadvisor". 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 AnthemLife, the password is 75293. You can also access Travel assistance benefits by calling: US and Canada (866) 295-4890, other locations (call collect) (202) 296-7482.

SpecialOffers@Anthem[sm]

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[sm] 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.

Life and Disability products underwritten by Anthem Life Insurance Company. In New York, Life and Disability products underwritten by Anthem Life & Disability Insurance Company.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. AL-2127 (5/12)

LINDSEY WILSON COLLEGE HEALTH BENEFIT PLAN

210 Lindsey Wilson Street, Columbia, KY 42728

270-384-7313

Employment Verification form for Spouse

****Any Spouse who is eligible for coverage through his/her own employer is not eligible for coverage from Lindsey Wilson College's health benefit plan.****

SECTION 1: This section to be completed by the participant (employee)

Participant (employee) name: _____ Participant Social Security number: XXX-XX-_____

SECTION 2: This section to be completed and signed by the spouse

Spouse name: _____ Spouse signature: _____

☐ **I am not employed** at this time and if I become employed, I will complete a new "Employment verification form" to terminate coverage for myself as of the date that coverage is available to me through my employer.

☐ **I am employed** at this time and authorize my employer to complete the information on this form.

SECTION 3: This section to be completed by the spouse s emp lo yer

Dear Employer:

Effective January 1, 2014, the Lindsey Wilson College Health Benefit Plan requires spouses to verify whether or not a spouse is eligible for coverage from the plan. For verification purposes, the employer must complete this "Employment Verification form" and return the completed form to the Lindsey Wilson College HR Office.

Please verify the following information:

☐ We **do not offer** medical insurance.

☐ We offer medical insurance but this **employee is not eligible** to enroll because: _____.

☐ We offer medical insurance, and this **employee is eligible to enroll** ___/___/_____in:
- □ Medical (date)
- □ Dental
- □ Vision

☐ We offer medical insurance, and this **employee is enrolled** effective ___/___/_____in:
- □ Medical (date)
- □ Dental
- □ Vision

☐ We offer medical insurance however, this **employee has chosen not to enroll** effective ___/___/_____in:
- □ Medical (date)
- □ Dental
- □ Vision

Company Name: _____

Company Benefits Representative: _____ _____

Name Signature

_____ _____

Telephone Date

Please return this form to: Lindsey Wilson College HR Office
210 Lindsey Wilson Street
Columbia, KY 42728
Or fax: 270 384 7373 Or Email: HR@LINDSEY.EDU

AUTHORIZATION TO VIEW DEPENDENT CLAIMS ONLINE

As a convenience to our participants ARC Administrators has established an online website where participants will be able to log in and view their individual health and dental claims. In addition to the individual participant's claims, upon written consent of the participant's dependents, the participant will be able to view their dependents health and dental claims as well. This authorization only has to be completed and returned to ARC Administrators if the participant wants to be able to view their dependents claims in the online system.

Section 1: This section to be completed by the participant (employee)

Participant (employee) Name:_____

Participant Member ID #:_____

Participant Signature:_____

Section 2: This section to be completed and signed by the spouse

By signing this authorization form I hereby give my spouse permission to view my health and dental claims in the online system.

Spouse Name: _____

Spouse Signature:_____

Section 3: This section to be completed and signed by any other covered dependent over the age of 18

By signing this authorization form I hereby give participant permission to view my health and dental claims in the online system.

Dependent Name:_____

Dependent Signature:_____

Dependent Name:_____

Dependent Signature:_____

Dependent Name:_____

Dependent Signature:_____

Completed Authorizations can be returned to ARC Administrators by the following methods:

Mail to:	Fax to:	Email to:
P.O. Box 12290 Lexington, KY 40582	859-243-0381	eligibility@arcsvs.com

Access to view participant's dependents health claims will not be granted without this completed authorization. If you have questions please contact us at 1-877-309-2955.