

Monthly Premium Schedule	First Product Selected		Employer Contribution	
	Basic	POS	Basic	POS
Emp Only				
Emp and 1 Child				
Emp and Children				
Emp and Spouse				
Emp and Family				
	Second Product Selected		Employer Contribution	
	Basic	POS	Basic	POS
Emp Only				
Emp and 1 Child				
Emp and Children				
Emp and Spouse				
Emp and Family				
	Third Product Selected		Employer Contribution	
	Basic	POS	Basic	POS
Emp Only				
Emp and 1 Child				
Emp and Children				
Emp and Spouse				
Emp and Family				

If Blue Advantage, KeyCare Group Number: # _____	Previous Carrier: _____	Binder Check: # _____	Amount: \$ _____
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Notes:

Broker/Agent Agreement: The Applicant authorizes the Health Maintenance Organization specified above (the HMO), to recognize the following broker/agent/or agency (if any) to be the Applicant's Agent of Record:

Name of Broker/Agent: _____ Broker/Agent ID#: _____
 Name of Agency/Agent: _____ Phone#: _____ FAX#: _____
 Address: _____

Broker/Agent Statement: I hereby certify that all information in the group enrollment summary and applications is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual requesting coverage, except as noted on the health questionnaire, as required. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the group and its employees.

Broker/Agent Signature: *[Signature]* Date: _____

Anthem Sales Representative: I hereby certify that all information has been verified.
 Signature: _____ Rep. Code #: _____
 FAX#: _____ Date: _____

Underwriting Approval: (printed name): _____
 Underwriter signature: _____ Underwriter code: _____
 Date: _____

HMO underwriting requirements must be met in order to be eligible for HMO coverage.
 If a POS plan is not currently offered, a group health plan or benefit plan that allows enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization panel must be offered concurrently to all eligible employees.

Group: _____ Date: _____

Signature: _____ Title: _____