Specialty Benefit Modification Form
For Dental, Vision, Life and Disability

To add or change dental, vision, life and/or disability coverage on an existing Anthem medical plan, complete this form and submit with a copy of the proposal. Any new enrollees or family additions must complete an Employee Application requesting coverage. No retroactive requests will be accepted.

Section 1: Company Information

Select one: ☐ New Enrollment ☐ Coverage Change	Group/Case No.	SIC Code (4 digits)	Requested Effective Date
Employer Name	Employer Tax ID	Agent Name	General Agent Name

Section 2: Dental Coverage — **Ineligible SIC Codes include Dental Offices #8021 and** Miscellaneous #9999

Select one:
☐ Employer Sponsored ☐ Voluntary

Choose your dental contribution:
Employer to contribute ______% per employee ______% per dependent (required on Dental Net only)

Plan Name: ____________________ Contract Code: ____________________

Plan Name: ____________________ Contract Code: ____________________

NOTE: Orthodontia coverage is only available for groups with five or more enrolled.

☐ **Bundled Rate:** Groups adding new dental with one additional line of new Specialty (e.g., vision, life or disability) are eligible to receive an additional 5% premium savings.

Section 3: Vision Coverage

Select one:
☐ Employer Sponsored (minimum of two subscribers must enroll; employer contribution between 50% and 100%)
☐ Voluntary (minimum of five subscribers must enroll; employer contribution between 0% and 49%)

Choose Employer Vision contribution:
________% per employee

Plan Name: ____________________ Contract Code: ____________________

Plan Name: ____________________ Contract Code: ____________________

☐ **Bundled Rate:** See Section 2 for details.

Section 4: Life & Disability Coverage — Offered by Anthem Blue Cross Life and Health Insurance Company

LIFE PRODUCT CONTRIBUTION		DISABILITY PRODUCT CONTRIBUTION	
Product Choice (minimum of two employees must enroll)	**Percentage**	**Product Choice** (minimum of two employees must enroll)	**Percentage**
☐ None		☐ None	
☐ Basic Life & AD&D	_________ %	☐ Short-Term Disability	________ %
☐ Basic Dependent Life	_________ %	☐ Long-Term Disability	________ %
☐ Optional Supplemental/Voluntary Life and AD&D*	_________ %	☐ Voluntary Short-Term Disability*	________ %
☐ Optional Supplemental/Voluntary Dependent Life*	_________ %	☐ Voluntary Long-Term Disability*	________ %
*Available for Groups of 10+		*Available for Groups of 10+	

Life and/or Disability Eligibility Waiting Period — Waive eligibility waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility waiting period for new eligible employees enrolling in Life and/or Disability plans after the group's coverage effective date the same as the Anthem medical policy waiting period? ☐ Yes ☐ No If no, enter the Life and Disability eligibility waiting period below.

Class Number	**Coverage description** (Ex: life, short-term disability, long-term disability, etc.)	**Description of eligibility waiting period** (Ex: date of hire, first of month following 60 days of continuous employment, etc.)

Section 5: Eligibility — Dental and Vision rates are based on total eligible, not enrolled

Number of eligible full-time employees (minimum 30 hours per week): ________

Number of employees enrolling in:
Dental: _______________ Vision: _______________ Life: _______________ Disability: _______________

Section 6: Prior Coverage

Has this group had coverage within 12 months of this application's signature date? ☐ Yes ☐ No

Replacing current plan?	**If yes, provide carrier name & plan type (DHMO, PPO) below:**	**Termination Date (MM/DD/YYYY):**	**Effective Date:**
Dental: ☐ Yes ☐ No			
Vision: ☐ Yes ☐ No			N/A
Life: ☐ Yes ☐ No			N/A
Disability: ☐ Yes ☐ No			N/A

Section 7: Signature

By signing below, I agree to the above condition of enrollment in addition to all other terms, limitations and conditions of the Group Benefit Agreement and/or Group Contract X ______________________________	Title	Date

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