Reset

GROUP INSURED APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
9000 Cameron Parkway Oklahoma City, Oklahoma 73114

APPLICANT INFORMATION

Name (Last, First, MI, Suffix)	**Gender** (M/F)	**Country of Citizenship**

Date of Birth (MM/DD/YYYY)	**Age**	**Social Security Number**	**Requested Effective Date** (MM/DD/YYYY)	**Date of Hire** (MM/DD/YYYY)	**Occupation**	**Salary** (Annually or Monthly)

Resident Address (Number and Street, City, State, Zip – Not a PO Box)

Mailing Address (if different than resident)

Work Phone Number (w/area code)	**Primary Phone Number** (w/area code)	**Email Address**

Employer Name	**MCP**

SPOUSE INFORMATION (Complete only if applying for spouse coverage.)

Name (Last, First, MI, Suffix)			**Country of Citizenship**
Date of Birth (MM/DD/YYYY)	**Age**	**Social Security Number**	**Gender** (M/F)

BENEFICIARY

Primary Name (Last, First, MI, Suffix)	**Relationship**	**Percentage**	**Product(s)** (if different)

Contingent Name (Last, First, MI, Suffix)	**Relationship**	**Percentage**	**Product(s)** (if different)

Within the past 12 months has the applicant (or spouse if applicable) used tobacco in any form?

Applicant (Yes/No): _____

Spouse (Yes/No): _____

PRODUCT SELECTION (Benefits applied for:)

					HOME OFFICE USE ONLY			
Product	Persons Covered[1]	Plan Amount	Premium	Premium Mode	Policy Number	Plan Code	MCH	Billing Distribution ID
TOTAL PREMIUM:			$ 0.00					

[1]z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; s=Spouse

HEALTH HISTORY	
Within the **past 12** months has any person to be covered age 18 or older been absent from work due to illness or medical treatment for a period of more than **5** consecutive working days (other than absences for childbirth with no complications, broken/fractured bones with full recovery or the flu)?	**Applicant (Yes/No):** _____

SIGNATURE AND ACKNOWLEDGEMENT

ELECTION: I hereby enroll, add or change, as selected above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay.

ACKNOWLEDGMENT: I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
- If applying for disability income coverage, **OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**
- "Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any. I further understand that any increase in coverage must be applied for and approved by the Company, and as explained in my Certificate, a new Pre-Existing Condition period will apply with respect to the increase.

I have received and reviewed a copy of the following consumer brochure form number(s): _____

I have also received and reviewed the outline of coverage, if applicable, and any other state mandated forms required at the time of application.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

I understand the following signature is acceptance and acknowledgement for each policy that is applied for under this application.

Applicant Signature or PIN _____ Date _____

Agent # _____ Print Agent Name (if any) _____

Agent Signature or PIN (if any) _____ Date _____

Help Us Help the Environment

Electronic delivery of policy documents can offer you access to the most up-to-date documents keeping them safe so that you can have access to them at any time.

If you would like to receive and manage your American Fidelity Assurance Company Policy Documents online electronically, please read the Consent to Electronic Delivery of Policy Documents and place your initials in the space provided below.

Consent to Electronic Delivery of Policy Documents

I hereby request and agree to Electronic Delivery of Policy Documents ("Consent"), if available, by American Fidelity Assurance Company (AFA).

Policy Documents
I understand that: (1) Policy Documents will be hosted on a secure Web site; (2) I will receive an e-mail from AFA to the e-mail address that I have designated below containing instructions and AFA's web address; (3) Electronic Delivery is in lieu of regular U.S. Mail delivery; (4) Electronic Delivery is sufficient to meet all requirements under the Policy; (5) paper copies of any and all electronically delivered Policy Documents are available to me upon my request; and (6) if I have executed more than one Consent, only my last election will be in effect.

Systems Requirements
I understand that in order to receive Policy Documents electronically, I must use a valid e-mail address, an Internet connection, and a computer that meets the following minimum requirements: Internet Explorer 6.0 or later and Adobe® Reader® 8.0 or newer, available free on www.afadvantage.com or www.adobe.com.

Revocation of Consent
I understand that either party may revoke this Consent unilaterally at any time with ten (10) days prior notice to the other party. The Certificateholder/Policy Owner may revoke by calling, toll-free: 1-800-654-8489; or by writing to: American Fidelity Assurance Company, 9000 Cameron Parkway, Oklahoma City, Oklahoma 73114-3701. Upon revocation of this Consent, AFA will communicate all future Policy Documents via regular U.S. Mail to the last known designated address of the Certificateholder/Policy Owner.

Transmittal of Policy Documents
I understand that I am responsible at all times, as the Certificateholder/Policy Owner, to notify AFA in writing of any and all changes associated with the transmittal of Policy Documents. That I, as the Certificateholder/Policy Owner, agree that I will hold AFA harmless with respect to any and all delivery errors caused by my failure to provide current and valid information for the receipt of Policy Documents.

By initialing in the box below, I ☐ **agree** ☐ **do not agree** to the Electronic Delivery of my Policy Documents.

INITIAL ABOVE	DATE

Name and designated electronic transmittal e-mail address of the Certificateholder/Policy Owner:

PRINTED NAME	E-MAIL ADDRESS