AmFirst Insurance Company Enrollment Form

Hand Print – Black Ink Only
This is an electronically processed form. Please PRINT in the boxes in capital letters:
ABCDEFG…12345 DO NOT TOUCH LINES

Group Name

Requested Effective Date
M O / D D / YEAR

Hire Date
M O / D D / YEAR

Last Name (Primary Insured)	First Name	MI	M/F	M O / D D / YEAR	AGE	SSN
Last Name (Spouse)	First Name	MI	M/F	M O / D D / YEAR	AGE	SSN
Last Name (Dependents)	First Name	MI	M/F	M O / D D / YEAR	AGE	Student Status

Please indicate yes in Student Status at left if full time students

Use this form for:

♣ New Application

♣ Additional Insured

♣ Delete Insured

Address

Work Phone

City

State

Zip -

Home Phone

Payment Mode
Group Payroll Deduction

Type of Coverage ♣ Employee ♣ Employee + Spouse ♣ Employee + Children ♣ Employee + Family

Plan #_____

Monthly Premium _____

Authorization, Agreements, Representations and Understanding

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. Consumer reporting agencies, or employer having information available as to diagnosis treatment and prognosis with respect to any physical or mental condition and/or treatment of me and other members, to give AmFirst Insurance Company , its reinsurers, or its legal representatives, any and all such information. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application for Insurance.

The agent and I certify that I have read or had read to me the complete application. I realize that any false statement or misrepresentation that is material to the risk or hazard assumed may result in loss of coverage under the coverage applied for, subject to the incontestable period, time limit on certain defenses and legal proceedings.

I understand that no agent can: a) accept risks; b) modify policies; or c) waive any rights or requirements of AmFirst Insurance Company. The acceptance of any certificate or policy issued on this application shall be an acceptance and ratification by me of all corrections, additions or changes made by AmFirst Insurance Company. Any changes are shown in the space labeled "Home Office Use." ; however, any change in the date of birth is subject to my written agreement.

I understand that coverage is effective when: a) the certificate or policy is issued by AmFirst Insurance Company; b) the certificate or policy is received and accepted by me; and c) the first full monthly premium is received and accepted by AmFirst Insurance Company; and d) if there has been no change in my health or occupation since the date below.

I understand that the certificate provides limited benefits, specifically only the benefits which I have selected and are set forth in the certificate itself.

WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

X _____

Signature of Proposed Insured Date

_____

Agent's Printed Name Agent Number

_____

Dated at City State