Application for Group Insurance to:
AmFirst Insurance Company
Administrative Office
P. O. Box 14067 • Jackson, MS 39236-4067

The Information provided by the Applicant in this Application will be the basis on which any insurance is issued. Incorrect Information could void Insurance.

Applicant	Employer Identification Number
Name of Business or Organization Principal Business or Activity	SIC Code

Physical Address: (Street Number and Name)	Billing Address: (If different from Physical Address)
City	City
State Zip	State Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:

Eligibility

- [W-2 employees or Contract (1099) employees are eligible. 1099 employees must have employer sponsorship and a common remitter.
- Applicant must be employed and be actively at work with the company for a minimum of 90 days prior to application to be eligible.
- Applicant must work 20 hours are more per week.
- Applicant must be under the age of age 65, benefits reduce to one half at age 65, and policy will terminate at age 70.
- Spouse must be under the age of age 65, benefits reduce to one half at age 65, and policy will terminate at age 70.
- Dependent children** under the age of 21. Full time students are eligible to age 25.
- Mental or physical handicap are eligible (age 21 or more years of age) if primarily supported by the insured and incapable of self-sustaining employment because of the mental or physical handicap.
- Individuals on Medicare are not eligible for this coverage.]

Insurance Applied For

[Affordable Medical Plan - Policy Form Series AF-HOSPIND

Attach copy of proposal or flier describing benefits selected
Plan #______________

Applicant will pay _______% of Employee or Member Costs and _____% of Dependent Costs

Important: The Affordable Medical Plan is NOT basic health insurance. This is limited benefit indemnity insurance. It is not a substitute for basic health coverage, major medical insurance, or any other medical expense reimbursement plan.]

Policy/ Certificate Delivery

[Send Policy & Certificate to: _____Agent _____Employer]

Payroll and Billing Information

Billing is alphabetical -12 monthly Premiums
Effective date: ___________ (1st of the month)

Make check payable to AmFirst Insurance Company.
$____________ (amount of attached check).

[ALL PREMIUMS ARE PAYABLE IN ADVANCE. THE FIRST PREMIUM MUST BE PAID PRIOR TO THE EFFECTIVE DATE OF INSURANCE.]

Agreements, Representations and Understanding

[I represent that all statements made herein are complete and true as of the date I signed this Application, and I understand that AmFirst Insurance Company (AF) will rely on these statements and this information as the basis for approving this Application.

I understand that the Insurance Policy for which I have applied is a limited benefit Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy's limitations and exclusions. For a complete listing of the plan provisions, as well as any limitations and exclusions, please refer to the Group Policy. Any provision of the Group Policy which, on it's Effective Date, does not agree with the laws of the state in which the Policy is written, will be amended to the minimum requirements of that state.

I understand that coverage is effective when: a) the Policy is issued by AmFirst Insurance Company b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by AmFirst Insurance Company.

We agree to make any necessary payroll deductions for any employee's share of the cost of this insurance (if any) and to remit the total premium for all insurance as premiums become due.

I understand that the Policyholder or AmFirst Insurance Company may terminate the Policy and any Rider(s) on any premium due date by giving at least 90 days written notice to the other party. The Policyholder is responsible for notifying the Insured of the termination or non-renewal of the Policy.

I understand that AmFirst Insurance Company and the Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

I represent that I have read and understand this form.]

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

On behalf of the Employer, this Application for Group Insurance is signed by

X ____ Print Name ____

Official Title ______________________________________

Date _______________

Agent Name (print) __________________________________Signature___________________________________