

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	Req. Eff Date MO / DD / YEAR	Hire Date MO / DD / YEAR			
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Last Name (Primary Insured)	First Name	MI	M/F	MO / DD / YEAR	AGE	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Last Name (Spouse)	First Name	MI	M/F	MO / DD / YEAR	AGE	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Last Name (Dependents)	First Name	MI	M/F	MO / DD / YEAR	AGE	Student Y/N	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div style="border: 1px solid black; padding: 5px; font-size: small;"> Please indicate yes in student status at left for <u>full time</u> students between age 19-25. </div> <input type="checkbox"/> New Application <input type="checkbox"/> Additional Insured <input type="checkbox"/> Delete Insured
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

Address	Work Phone	Payment Mode Group Payroll Deduction
<input type="text"/>	<input type="text"/>	
City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>
Home Phone		
<input type="text"/>		

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

Plan Design Code _____

Monthly Premium _____

Are all proposed insured now covered under a Major Medical or comprehensive Health Plan?

yes no

If "NO" list persons not eligible for coverage: _____

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, 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 amount, class, plan or 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 full first premium is paid or an authorization for payroll deduction 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: Any person who knowingly, and with intent to injure, defraud or deceive any Company, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

X

Signature of Proposed Insured

Date

X

Signature of Agent

Agent's Printed Name

Agent Number

Dated at

City

State

Agent State License Identification Number