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 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 Y/N

Please indicate yes in student status at left for full time students between age 19-25.

☐ 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 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.

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