

Eligibility/Waiting Period: _____

{Eligible Classes: _____}

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" provisions of the Policy.

Insurance Applied For

Employer Contribution ___ {Premium Saver Plan} ___ {HSA Saver Plan} ___ {Med Bridge Plan}

Voluntary (Employee Paid Plans) ___ {Med Bridge Plan}

Requested Effective Date _____

Employer will pay _____% or \$_____ of Employee Costs and _____% or \$_____ of Dependent Costs

{Important Note: All persons (100 % participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be covered on Employer Contribution plans listed above.

Plan Design Selection

ATTACH FLIER OR PROPOSAL THAT DESCRIBES THE SPECIFIC BENEFITS

Applicable to {all} {Accident}{Sickness}{Inpatient}{and}{Outpatient} Benefits {Only}

Deductible: \$_____ Coinsurance: _____% Out-of-Pocket Maximum (Coinsurance Limit) \$_____

Maximum Total Benefit Amount \$_____

Per Year Benefit Maximum Basis: Plan Year Calendar Year

Comments _____

This Section is for Office Use Only

ACCIDENT BENEFIT

{Co-payment Amount \$_____} {Per visit}

Maximum Benefit Amount All Covered Facilities per Year: \$_____

Maximum Benefit Amount for In-Hospital Confinement per Year \$_____

Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$_____

OPTIONAL RIDERS

{Sickness Benefit Rider:} { Yes No}

{Co-payment Amount \$_____} {Per visit}

{Maximum Benefit Amount All Covered Facilities per Year: \$_____}

{Maximum Benefit Amount for In-Hospital Confinement per Year \$_____}

{Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$_____}

{Hospital Indemnity Sickness Benefit Rider} { Yes No}

{Outpatient Physicians Expense Rider} { Yes No}

{Ambulance Benefit Rider} { Yes No}

{Generic Outpatient Prescription Drug Rider} { Yes No}

{Brand {and Generic} Prescription Drug Rider} { Yes No}

{Outpatient Physical and Wellness Examination Rider} { Yes No}

{Outpatient Diagnostic Test and Lab Rider} { Yes No}

{Allied Services Rider} { Yes No}

{Prior Plan Deductible Credit Rider} { Yes No}

Policy/Certificate Delivery

Send Policy & Certificate to: _____ Agent _____ Employer

Payroll and Billing Information

{Billing is alphabetical -12 monthly Premiums}
Effective Date can be {the 1st or the 15th 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 (AmFirst) will rely on these statements and this information as the basis for approving this Application.

I understand that the Group Accident 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, if any.

I understand that only those employees and dependents covered under our company's major medical or comprehensive health plan are eligible for coverage.

Check One

{I **represent** that {100%} of eligible employees and dependents will be enrolled in the plan}. _____

{I **represent** that this plan will be offered on a voluntary basis} _____

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

{**We agree** to make any necessary payroll deductions for any employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums and any applicable administrative fee due under the insurance Policy issued.}

I understand that the **Policyholder may** terminate the Policy and any Rider(s) on any premium due date by **giving** written notice to the other party. The Policyholder is responsible for notifying the Insureds of the termination or non-renewal of the Policy.

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

I represent that the information herein is true and complete, as of the date I signed this Application, and that I have read and understand this form.

{**I acknowledge and understand** that any misrepresentation on this Application by my agent or me may result in the cancellation or rescission of any Policy issued based on this Application.}

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

X _____ Print Name _____

Official Title _____ this _____ day of _____

Agent Name (print) _____ Signature _____

Agent State Licenses identification Number _____

