

Insurance Applied For

AF-GAP-P series Group Accident Plan Does a Major Medical Plan or Comprehensive Health Plan cover all Eligible Persons? <input type="checkbox"/> Yes <input type="checkbox"/> No Important Note: Any person who is not insured by a Major Medical Plan or Comprehensive Health Plan is not eligible for insurance under this policy form. Minimum number of applications per group is 5. Is this a voluntary enrollment or is the employer paying part of the premium? _____ Employer will pay _____% of Employee Costs and _____% of Dependent Costs _____ What is the Major Medical Deductible Amount \$ _____ What is the Major Medical Co-Insurance Out of pocket Amount _____ % _____? <hr/> <u>Group Accident Plan Design</u> 1 [CALENDAR YEAR] _____ 2. REQUESTED EFFECTIVE DATE _____ 3. SUPPLEMENTAL DEDUCTIBLE [PER PERSON PER CALENDAR YEAR] \$ _____ 4. SUPPLEMENTAL CO-INSURANCE % _____ \$ _____ OUT OF POCKET [PER PERSON PER CALENDAR YEAR] _____ BENEFITS Plan Design Code _____ or (Attach Flier Describing Benefits)

This Section is for Office Use Only

RIDERS 1. GENERIC OUTPATIENT PRESCRIPTION DRUG RIDER YES ___ NO ___ 2. BRAND AND GENERIC OUTPATIENT PRESCRIPTION DRUG RIDER YES ___ NO ___ 3. OUTPATIENT PHYSICAL EXAMINATION AND WELLNESS RIDER YES ___ NO ___ 4. ALLIED SERVICE RIDER YES ___ NO ___ 5. CREDIT FOR PRIOR PLAN DEDUCTIBLE RIDER YES ___ NO ___ 6. EXCLUSION EXCEPTION RIDER YES ___ NO ___
--

Payroll and Billing Information (Check All That Apply) For Normal Payday, Give Day of Week (Monday, Friday, etc.)

<input type="checkbox"/> Weekly Normal Payday: _____	<input type="checkbox"/> Bi-Weekly (Every other Week) Normal Payday: _____
<input type="checkbox"/> Semi-Monthly (Twice per Month) Normal Pay Dates: _____ and _____ day of the month.	<input type="checkbox"/> Monthly Normal Pay Date: _____ day of the month.
<input type="checkbox"/> Other: _____	Billings must be: <input type="checkbox"/> Alphabetic <input type="checkbox"/> Numeric by Social Security Number <input type="checkbox"/> Numeric by Employee Number

“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.”

ALL PREMIUMS ARE PAYABLE IN ADVANCE OF THE EFFECTIVE DATE OF INSURANCE.

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

X _____ Print Name _____
 Official Title _____, this _____ day of _____