

**Application for Group Accident Limited Benefit Insurance to:
AmFirst Insurance Company**

5722 I-55 North Frontage Road • Jackson, MS 39211
or P.O. Box 14067 Jackson, MS 39236

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

Legal Name of Employer (include d/b/a):		Employer Identification Number	
Principal Business or Activity		SIC Code	
Physical Address: (Street Number and Name)		Billing Address: (If bill is to be split and sent to more than one billing address please indicate here and give addresses on an attached sheet.)	
City		City	
State	Zip	State	Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:
Email Address:	Email Address:
Fax Number	Fax Number

Employer's Major Medical or Comprehensive Plan Data

Major Medical Plan Carrier _____
Major Medical Deductible Amount \$ _____
Major Medical Coinsurance % _____ to Maximum Out of pocket (Coinsurance Limit) Amount \$ _____
Are Major Medical Deductibles & Coinsurance per Plan Year or per Calendar Year? _____
Major Medical Plan Anniversary Date _____
Number of Covered: Employees _____ Dependent Spouses _____ Dependent Children _____

Eligibility

Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:

Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee) -

All active full time employees working 18 hours or more per week and who are under the age seventy will be eligible for coverage. Each insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first dependent.

Eligible Person - If employer participates in paying the premiums -

1. An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan. Eligible new employees or dependents may be added subject to the terms of the Policy.

Eligibility _____

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 (circle "All" if applicable, otherwise circle applicable coverage only) Accident /
Sickness / Inpatient/ Outpatient Benefits

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

Maximum Total Benefit Amount \$_____

Per Year Benefit Maximum Basis: Plan Year Calendar Year

Comments _____

This Section 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 Physician's Expense Rider Yes No

Ambulance Benefit Rider Yes No

Generic Outpatient Prescription Drug Rider Yes No

Brand 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 (AF) 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 AF; b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by AF.

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 or AF 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 Insureds of the termination or non-renewal of the Policy.

I understand that AF 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.

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 _____

