

AmFirst Insurance Company

5722 I-55 North Frontage Road, Jackson, MS 39211
 P. O. Box 14067
 Jackson, Mississippi 39236 Telephone: 800-800-1397

APPLICATION FOR ENROLLMENT

Organization Name & Number: (if applicable)

Effective Date: _____

APPLICATION FOR INSURANCE

New Application Additional Insured to Certificate No. _____

NAME	First	Middle	Last	Social Security #	Birth Date	Age	Sex
Primary Insured:							
Spouse: (Optional)							
Dependent Children: (Optional)							
Resident Address:			Billing Address:				
City	State	Zip	City	State	Zip		
Occupation:			Employer:				
Home Telephone: ()			Work Telephone: ()				
Payment Mode: <input type="checkbox"/> Monthly Payroll Deduction							

Beneficiary: _____ Relationship: _____

HEALTH QUESTIONS. (To Be Answered Upon Late Enrollment) If any question is answered "Yes," list the applicable person below who is not eligible for coverage.

- During the past 5 years has any person intended to be insured:
 - (i) consulted with any licensed member of the medical profession about any of the following; or (ii) been treated by any member of the medical profession for any of the following:

	YES	NO
a.) disease or abnormalities of the brain or nervous system, including, but not limited to, stroke, epilepsy, seizure, paralysis, Alzheimer's Disease or other dementia, or any degenerative neurological disorder?.....	___	___
b.) diseases or abnormalities of the heart, including, but not limited to heart attack?.....	___	___
c.) cancer, leukemia or Hodgkin's Disease?.....	___	___
d.) emphysema, cystic fibrosis, chronic obstructive pulmonary disease, diabetes, cirrhosis, or Crohn's Disease?.....	___	___
- During the past 10 years, has any person intended to be insured:
 - Been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?.....
- During the past 6 months, has any person intended to be insured:
 - a.) other than for any accident, had any hospital confinement of 3 days or longer?.....
 - b.) been advised by a medical professional to have or contemplate having a diagnostic test or surgery which has not been completed?.....
- Is any person or family member to be insured now pregnant (if Yes, please provide diagnosis)?.....
- During the past 3 years, has any person intended to be insured been declined for any health or life insurance?.....
- Does any person intended to be insured, have current coverage under a Medicare Program?.....

SELECTION OF COVERAGE	Mode Premium*				List any person(s) who answered "Yes" to any questions listed above. This person(s) is/are <u>not</u> eligible for coverage.
	Individual	Individual & Spouse	Individual & Children	Full Family	
Plan Number:	\$	\$	\$	\$	_____

Total Premium	\$	\$	\$	\$	_____

Home Office Use Only:

List all health policies in force or applied for (if none, so state). Indicate if the policy applied for is intended to replace said existing policy.					
Name of Insured	Company Name	Policy #	Type	Issue Year	Replacement Yes / No
					<input type="checkbox"/> <input type="checkbox"/>

AGREEMENTS, REPRESENTATIONS AND UNDERSTANDING

I certify that I have completed the application in my own handwriting or I certify that I have read the completed 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 the acceptance of any certificate 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 amount, class, plan or date of birth is subject to my written consent.

I understand that coverage is effective when: a) the certificate is issued by AmFirst Insurance Company; b) the certificate 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 this plan will not pay benefits for preexisting conditions during the first 12 months of coverage. **I understand** that the certificate provides limited benefits, specifically only the benefits which have been selected by the Sponsoring Organization and are set forth in the certificate itself.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, the Medical Information Bureau, the Department of Motor Vehicle Registration and paramedical facilities, that retains public records or knowledge regarding my, or my spouse's and our children's health or wellbeing to give AmFirst Insurance Company or its reinsurers or its legal representative, 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. This information will be used for the purposes of underwriting and insurability determinations. Information received regarding my insurability, that of my spouse or my children may be disclosed to the aforementioned institutions for purposes of compliance, clarification, and explanation. This authorization is valid for **twenty-four** months from the date the authorization is signed. You, or a person authorized to act on your behalf, are entitled to receive a copy of this authorization form. A picture copy of this authorization shall be as valid as the original. **This authorization may be revoked by the proposed insured at anytime.**

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.

Signature of Proposed Insured

Date

Signature of Spouse (if proposed to be insured)

Date

Return this application to:

Agent (printed) Name

Agent Number

Street Address

Agent's State License Identification Number

City, State, Zip

Signature of Agent