

**AmFirst Insurance Company**

5722 I-55 North Frontage Road, Jackson, MS 39206  
 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.**      If any question is answered "Yes", list the applicable person below who is not eligible for coverage.

1. During the past 5 years has any person intended to be insured: (i.) had symptoms of any of the following; (ii.) consulted with any member of the medical profession about any of the following; or (iii.) 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?.....	___	___
2. During the past 10 years, has any person intended to be insured:
 

a.) been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV)?.....	___	___
b.) tested positive for the HIV Infection?.....	___	___
3. \_\_\_\_\_
4. 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 to have or contemplate having a diagnostic test or surgery which has not been completed?.....	___	___
4. Is any person intended to be insured or any family member (whether or not named in this application) now pregnant?..    \_\_\_
5. During the past 3 years, has any person intended to be insured been declined for any health or life insurance?.....    \_\_\_
6. 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:

