

**GROUP APPLICATION**

**AMERICAN FIDELITY ASSURANCE COMPANY**



2000 N. Classen Blvd., Oklahoma City, Oklahoma 73106

**PROPOSED INSURED**

Last Name		(maiden name)		First Name	Full Middle Name	Suffix
Age	Date of Birth Mo. Day Yr.	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Soc. Sec. Number	Requested Eff. Date Mo. Day Yr.	Date of Employment Mo. Day Yr.	
Number and Street				Work Phone # ( )	Home Phone # ( )	
City				State	Zip	State of Birth
Employer <b>Mississippi State University</b>		MCP#	Salary \$	Annual <input type="checkbox"/> Monthly <input type="checkbox"/>	Occupation	

Do you now have or have you ever had any other coverage with us? Yes  No   
 If so, write the existing Customer Number in the box in the upper right corner

Product	A/C <sup>1</sup>	MCH #	Payor #	HMC <sup>2</sup>	Benefits Applied For:			Employee Prem.	Employer Prem.	Total Prem.
					Plan	Amt.	Mode			
	<input type="checkbox"/>			<input type="checkbox"/>						
	<input type="checkbox"/>			<input type="checkbox"/>						
	<input type="checkbox"/>			<input type="checkbox"/>						
	<input type="checkbox"/>			<input type="checkbox"/>						
	<input type="checkbox"/>			<input type="checkbox"/>						
	<input type="checkbox"/>			<input type="checkbox"/>						

Totals: \_\_\_\_\_ Per Month

<sup>1</sup>A=Add C=Change

<sup>2</sup>Household members covered (z=Individual) (y=Individual & Spouse) (t=Child(ren)) (s=Spouse) (x=Individual, Spouse & Child(ren)) (w=Individual & Child) (v=Individual & Children) (u=Spouse & Child(ren))

Is the coverage applied for intended to replace or be in addition to any coverage you now have? Yes  No

**BENEFICIARY**

First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured
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**AUTHORIZATION**

I hereby enroll, add or change, as checked above, coverages of group insurance for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay. I have decided, after understanding and careful thought, not to take advantage of the other unchecked coverages for which I am eligible. I understand that proof of good health will be required for me and/or my dependents if I decide to apply for any available coverage 31 days after the date of eligibility. Such proof will be at my own expense. **ANY CHANGE REQUIRES WRITTEN NOTICE.** To the best of my knowledge and belief, the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete. I understand and agree: a) that the Company may rely upon such answers as the basis of my contract; and b) that no coverage will take effect until a Policy or Certificate is issued. I understand that "pre-existing conditions" are generally not covered under the coverage(s) applied for. I should read my Certificate for a more detailed explanation of the pre-existing exclusion or limitation, if any. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by the Company. **IF APPLYING FOR DISABILITY INCOME COVERAGE, I UNDERSTAND THAT OTHER INCOME I AM ENTITLED TO RECEIVE WILL REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

\_\_\_\_\_  
AGENT (where required by law)

Date \_\_\_\_\_

Agent # \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE (Applicant)

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**APPLICANT INFORMATION**

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Name	Date of Birth	Ht.	Wt.
A. Proposed insured			
B. Spouse			
C. Child			
D. Child			
E. Child			

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**MEDICAL INFORMATION**

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I. Please indicate if any person to be insured has ever been treated for or diagnosed by a physician or practitioner as having any of the following. This includes but is not limited to taking medication for any of the following. Underline any specific condition below.

- |  |  |   |
|--|--|---|
| 1. Adrenal/Pituitary Disorders                         | 13. Currently Pregnant                 | 28. Lymphatic Disorder                        |
| 2. Acquired Immune Deficiency/<br>AIDS Related Complex | 14. Diabetes                           | 29. Surgery within last 5 years               |
| 3. Alcohol Addiction/Abuse                             | 15. Diagnostic Testing                 | 30. Mental Illness/Emotional<br>Disorder      |
| 4. Aneurysm/Stroke                                     | 16. Dizziness/Loss of Consciousness    | 31. Neurological Disorders/M.S.               |
| 5. Asthma/Chronic Bronchitis                           | 17. Drug Addiction/Abuse               | 32. Pancreatitis                              |
| 6. Arthritis/Gout/Joint Disorder                       | 18. Epilepsy/Seizures/Convulsions      | 33. Paralysis/Polio Residuals                 |
| 7. Birth Defects/Congenital<br>Abnormality             | 19. Reproductive/Breast Disorders      | 34. Proctitis/Rectal Disorder                 |
| 8. Blood Disorder/Transfusion/<br>Hemorrhage           | 20. GI Disorder/Ulcer/Crohn's          | 35. Respiratory/Tuberculosis                  |
| 9. Cancer/Leukemia/Hodgkins                            | 21. Gonorrhea/Syphilis                 | 36. Tumor/Abscess/Cyst                        |
| 10. Circulatory/Vascular Disorder                      | 22. Heart Disease, Disorder/Angina     | 37. Any Other Health Conditions<br>Not Listed |
| 11. Ulcerative Colitis                                 | 23. Immunodeficiency Disorder          |   |
| 12. Complications of Pregnancy                         | 24. Kidney/Bladder/Prostate Disorder   |   |
|  | 25. Liver Disorder/Hepatitis/Cirrhosis |   |
|  | 26. Lung Disorder/Respiratory          |   |
|  | 27. Systemic Lupus Erythematosus       |   |

II. Any Other Medical Treatment Recommended but NOT YET COMPLETED: \_\_\_\_\_

III. I have reviewed all of the above medical conditions and believe my answers to be complete. (Please initial)  
\_\_\_\_\_

IV. Give details to all answers. Indicate below: name of person; dates and condition code number(s) of treatment; diagnoses; duration; outcomes; and names and addresses of all attending physicians and medical facilities. If necessary use a separate sheet of paper, dated and signed.

V. In the spaces below, indicate all physicians visits in the last 5 years. Include physician's name and address, dates, reasons and results of each visit. In space a., please name the physician who is most likely to have your complete medical records.

Patient's Name	Physician's Name and Address	Dates	Reasons (Code #)	Results
a.				
b.				
c.				
d.				
e.				

VI. Are you currently, actively at work and able to perform the duties of your occupation? Yes  No

VII. Are you covered by Workers' Compensation? Yes  No

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**REMARKS**

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