Payroll

ACCIDENT-ONLY INSURANCE (A36000 Series)

☒ New
☐ Conversion
☐ Add CI Rider Only
☐ Convert CI Rider Only

Policy Number:

Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

Please Print in Black Ink – To Be Completed by Proposed Insured

* Proposed Insured's Name _____ (Last) _____ (First) _____ (MI)

* DOB _____ (Month/Day/Year) * Sex _____ * SSN _____ - _____ - _____

* Address _____ (Street or Post Office Box) _____ (Apt. No.)

* City _____ * State _____ * ZIP _____

* Telephone ( ) _____ ☐ Home ☐ Work ☐ Cell * Best Time to Call _____

* Email Address _____

* Are you applying for Dependent Child(ren) coverage? ☐ Yes ☐ No
If yes, Dependent Children must be under age 26 as of the Effective Date of coverage.

Write Spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no Spouse or your Spouse is not to be covered, put N/A in the space below.

* Spouse's Name _____ (Last) _____ (First) _____ (MI) DOB _____ (Month/Day/Year) Sex _____

Account Name Mississippi State University Account No. R9474

Name of Employer Mississippi State University Type of Business School

* Job Duties _____

* Job Title _____

Occupation Class A (Completed by associate/agent) Industry Code A (Completed by associate/agent)

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTION

* 1. Are you, the Proposed Insured, actively at work with the employer listed above? ☐ Yes ☐ No
If no, a policy will not be issued; therefore, do not submit this application.

* Is this insurance intended to replace any other health insurance now in force? ☐ Yes ☐ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

* Does anyone to be covered currently have any other Accident coverage with Aflac or have you, the Proposed Insured, had any other Accident coverage with Aflac that terminated within the last six months? ☐ Yes ☐ No
If yes, or we determine that other Accident coverage was in force within the last six months, this application will be processed as a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions and replacement of coverage.

Policy Number: _____

If applying for optional CIRIDER, please answer the following questions:

Is the lump sum critical illness insurance rider (Aflac Plus Rider) intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Is anyone to be covered also covered under any other Aflac Plus Rider? ❑ Yes ❑ No
If yes, anyone covered under an existing Aflac Plus Rider cannot be covered under the new rider; therefore, the new rider will not be issued.

Are you applying to convert your current HSA-compatible Aflac Plus Rider (Series CIRIDERH) to the Aflac Plus Rider (Series CIRIDER) that is not HSA-compatible? ❑ Yes ❑ No
If yes, please complete the Notice and Acknowledgment Regarding Conversion form provided by your associate/agent.

*	Check Coverage Desired:	❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

Class: ☒ A ☐ B ☐ C ☐ D ☐ E ☒ Pre-Tax or ❑ After-Tax

SELECT ONE TYPE OF COVERAGE: ☒ 24-Hour Accident-Only ❑ Off-the-Job Accident-Only (available on Option 3 only)

SELECT ONE PLAN OPTION (Issue Ages 18-75):	❑ Option 1	❑ Option 2	☒ Option 3	❑ Option 4

Optional Riders (Issue Ages 18-70):	
❑ Additional Accidental-Death Benefit Rider Series A36050	☒After-Tax Only
Select One Rider: ❑ Aflac Plus Rider (Series CIRIDER) ❑ Aflac Plus Rider (Series CIRIDERH) Options: ❑ Retain current rider ❑ Convert current rider	❑ Pre-Tax or ❑ After-Tax

No Rider Allowed

Billing Method:
☒ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
☒ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If the B/D or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ *Assoc./Agent's No. _____

* Billable Premium $ _____ Premium Collected $ _____ *Sit. Code _____

BENEFICIARY INFORMATION

PLEASE NOTE: Your beneficiary will be your estate unless otherwise indicated.

If you name a trust as your beneficiary, please include full name of trust.

We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. We suggest you obtain legal advice before naming a minor child as your beneficiary.

Primary beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

* (1) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(2) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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* **Contingent beneficiary(ies):** **NOTE: Total % of Proceeds must equal 100%**

(1) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(2) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy and/or rider(s) will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has reached his or her 76th birthday before the Effective Date of coverage. If I am applying for an optional rider, I understand that the rider I am applying for will not cover any person who has reached his or her 71st birthday before the Effective Date of coverage.
- If applicable, I understand that Dependent Children, if any, must be under age 26 as of the Effective Date of coverage. Once covered, Dependent Children will continue to be covered until their 26th birthday. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue the coverage on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium.
- I acknowledge receipt of, if applicable:
  - ☐ Replacement Notice
  - ☒ Outline of Coverage
  - ☐ Aflac Plus Rider Conversion Notice
  - ☐ Aflac Plus Rider Outline of Coverage
  - ☐ *Guide to Health Insurance for People With Medicare*
  - ☐ Electronic Delivery Notice
  - ☐ Aflac Plus Rider Replacement Notice
- I understand that (1) the policy, together with the applications, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance, and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the purchase of the policy and/or rider(s) is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies and/or rider(s) may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current Aflac policy and/or rider(s) and its/their benefits for the benefits provided in this Aflac policy.

* **Proposed Insured's Initials** _____

- I acknowledge that I was offered the optional rider(s), and I have personally determined which, if any, are best for me.

* **Proposed Insured's Initials** _____

- I have read, or had read to me, the statements and answers I have provided on this application. I understand that the policy and/or rider(s) are to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties, but that material misrepresentations herein may result in loss of coverage under the policy and/or rider(s).

ADDITIONAL APPLICANT'S STATEMENTS AND AGREEMENTS FOR CIRIDER:

- I understand that coverage is not provided for any illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

* **Proposed Insured's Initials** _____

- If this is an application for a conversion of coverage, I understand that: (1) the Time Limit on Certain Defenses provision will run from the Effective Date of the new coverage, (2) the original coverage(s) will be terminated as of the Effective Date of the new coverage, and (3) the Pre-existing Conditions provision in the new coverage will run from the original coverage's Effective Date.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim, or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

* I prefer to receive an electronic copy of my policy instead of a paper copy. ☐ Yes ☐ No
If yes, please enter your email address on Page 1.

The policy provides limited benefits. Review your policy carefully.

* Signed and Dated at _____ on _____
City and State Date

* Proposed Insured's Signature _____

I certify that I personally saw the Proposed Insured when the application was written, and each question was asked of the Proposed Insured and answered as recorded. All answers above are correct to the best of my knowledge.

* Associate's/Agent's Signature _____ * Date _____
Licensed Associate/Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AFLAC.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEBSITE AT AFLAC.COM.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999

STATEMENT OF UNDERSTANDING AND AGREEMENT

I, the undersigned, understand and agree that the: (check all that apply)

- ☐ Cancer/Specified Disease
- ☐ Hospital Intensive Care
- ☐ Hospital Indemnity
- ☒ Accident
- ☐ Short Term Disability
- ☐ Life
- ☐ Specified Health Event
- ☐ Dental
- ☐ Payroll Long-Term Care
- ☐ Hospital Confinement Sickness Indemnity
- ☐ Vision

policy (policies) that I am applying for or if already issued, will not be effective until _____ _____. No benefits will be due to me or any family members, if applicable, and Aflac will not be liable for any claims for loss incurred prior to the effective date of the policy (policies) listed above.

Reissues only
_____(policyholder's initials) I certify my medical condition has not changed from the time I originally applied for coverage and I understand that any pre-existing condition clauses and applicable waiting periods will begin as of the newly selected effective date above.

* Applicant's/Policyholder's Printed Name: _____

* Address: _____

Policy Number: _____

* Signature of Applicant/Policyholder: _____

* Date Signed: _____

*Signature of Associate: _____

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
WORLDWIDE HEADQUARTERS: COLUMBUS, GEORGIA 31999
A STOCK COMPANY

IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS

READ THE FOLLOWING INFORMATION CAREFULLY.

1. **THE POLICY FOR WHICH YOU HAVE APPLIED INCLUDES A BINDING ARBITRATION AGREEMENT.**

2. **THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISPUTE RELATED TO THIS POLICY MUST BE RESOLVED BY ARBITRATION AND NOT IN A COURT OF LAW.**

3. **THE RESULTS OF THE ARBITRATION ARE FINAL AND BINDING ON YOU AND THE INSURANCE COMPANY.**

4. **IN AN ARBITRATION, ONE OR MORE ARBITRATORS, WHO ARE INDEPENDENT, NEUTRAL DECISION MAKERS, RENDER A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES.**

5. **WHEN YOU ACCEPT THIS INSURANCE POLICY YOU AGREE TO RESOLVE ANY DISPUTE RELATED TO THE POLICY BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT, INCLUDING A TRIAL BY JURY.**

6. **BINDING ARBITRATION GENERALLY TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY.**

7. **SHOULD YOU NEED ADDITIONAL INFORMATION REGARDING THE BINDING ARBITRATION PROVISION IN THE POLICY, YOU MAY CONTACT OUR TOLL FREE ASSISTANCE LINE AT 1-800-99-AFLAC (1-800-992-3522).**

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I HAVE READ THIS STATEMENT. I UNDERSTAND THAT I AM VOLUNTARILY SURRENDERING MY RIGHT TO HAVE ANY DISPUTE BETWEEN THE INSURANCE COMPANY AND MYSELF RESOLVED IN COURT. THIS MEANS I AM WAIVING MY RIGHT TO A TRIAL BY JURY.

I UNDERSTAND THAT UPON RECEIPT OF THE POLICY, I SHOULD READ THE ARBITRATION CLAUSE CONTAINED IN THE POLICY AND THAT I HAVE THE RIGHT TO REJECT THIS POLICY WITHIN FIVE (5) DAYS OF THE DATE OF DELIVERY IF I DO NOT WANT TO ACCEPT THE REQUIREMENT FOR ARBITRATION.

I UNDERSTAND THAT THIS SAME TYPE OF INSURANCE MAY BE AVAILABLE THROUGH AN INSURANCE COMPANY THAT DOES NOT REQUIRE THAT POLICY RELATED DISPUTES BE RESOLVED BY BINDING ARBITRATION.

* _____	* _____	* _____
APPLICANT/INSURED	**DATE**	**TIME**
* _____	* _____	* _____
AGENT	**DATE**	**TIME**

* AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

*	**Primary Policyholder's Name:** **SSN**(optional): **Date of Birth:**
	Policy Number(s):
*	**Address:**
	Name of Individual Subject to Disclosure (if not the primary policyholder): **Date of Birth:**
*	**Relationship to Primary Policyholder:** ☐ Self ☐ Spouse ☐ Domestic Partner

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

* _____ * _____

Signature of Individual Subject to Disclosure — Date Signed

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

* _____ * _____

Printed Name of Legal/Personal Representative — Legal Relationship *(e.g. Power of Attorney)*

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, GA 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).

Suitability Notice

I, _____, have reviewed the benefits and premium of the insurance
Proposed Insured's Name

policy(ies) and/or riders that I am applying for and agree to the following.

- I understand the impact that the premium for this coverage has on my paycheck/income;
- I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and
- I have considered all of my existing health insurance coverage, with Aflac and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

* Proposed Insured's Signature _____ Date _____

I certify that I have advised the applicant to consider the impact that this Aflac coverage has on his or her paycheck/income, and I agree with the applicant's decision that it is appropriate for purchase.

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent

AFLAC Accident Advantage Application Forms Instructions:

Everything with a star (*) on AFLAC is a required field.

Page 1

- Enter your last name, first name and middle initial
- Enter your date of birth
- Enter M or F for sex
- Enter your social security number
- Enter your address including City, State and Zip
- Enter your telephone number (along with best time to call)
- Enter your email address
- Check Yes or No when asked if you are applying for Dependent child(ren) coverage.
- For spouse's name: ***ONLY write in Spouse name and information if you are covering your spouse!** If no spouse will be covered on your plan, write "N/A" in the spouse's name blank.
- Enter your job duties and then job title on the line below duties.
- There are a couple of eligibility questions at the bottom of page 1. Check yes to question 1 stating that you are actively at work and the insured.
- Answer yes or no to the question asking if this policy is intended to replace another policy still in force. If yes, write in the policy number that this is replacing.
- Answer yes or no to the questions asking if you or anyone else being covered has had coverage with AFLAC Accident in the last 6 months.

Page 2

- You will skip the first 3 Yes or No questions as you are not applying for an option CIRIDER with this policy.
- Check the coverage desired by marking: Individual, Named insured/spouse only, one-parent family, or two-parent family
- At the bottom of the page, the billable premium and Associate /Agent number will be populated by AFLAC.

Page 3

- Enter the primary beneficiary(ies) by listing name, address, telephone, social security, DOB, and the relationship to you.
- Include the % of proceeds you would like this person(s) to receive.
- Enter the contingent beneficiary(ies) by listing name, address, telephone, social security, DOB, and the relationship to you.
- Include the % of proceeds you would like this person(s) to receive.

Page 4

- You will initial in the 3 places indicated

Page 5

- This is asking if you would like to receive an electronic copy of your new policy instead of a paper copy. You will check Yes or No.

- Enter the City and State along with the date you are signing this form.
- Your signature and date go below that.

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- This page is for Informational purposes only

Statement of Understanding and Agreement.

- The middle of the page is where you will fill in the blank with the date this policy will start or become effective (for new hire enrollment). This date will not be your hire date but will typically be the same date that your other optional coverages begin. For instance, if your hire date is July 15th, your effective date for Accident coverage will be September 1. If you sign up during open enrollment, your effective date will be January 1 of the new year; your premiums will start deducting December 15 of the current year.

Important Notice about the Policy of Insurance for which you have Applied.

- This is only for your information.

Acknowledgement of Arbitration Agreement.

- Sign and date (the agent will sign in their section).

Authorization to Obtain Information.

- You will print your name as the Primary Policyholder's Name.
- Enter your social security number
- Enter your date of birth.
- Since the Policy number is not yet assigned, you will leave this blank.
- Enter your address
- Check relationship to Primary Policy holder.
- Sign and date at the bottom.

Suitability Notice.

- You will print your name as the "Proposed Insured's Name".
- You will then sign and date at the bottom.

Please send the completed form to the Human Resource Department via:

- In person: 245 Barr Ave, 150 McArthur Hall
- U. S. Mail: PO Box 9603, Mississippi State, MS 39762
- Fax: 662 325-0753
- Secure e-mail: contact your benefit specialist listed on the website: hrm.msstate.edu for information how to send secure email. To find your benefit specialist, view the home page, about us, our staff.
- Campus mailstop 9603