Reset

GROUP INSURED APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
9000 Cameron Parkway Oklahoma City, Oklahoma 73114

APPLICANT INFORMATION

Name (Last, First, MI, Suffix)						Gender (M/F)	Country of Citizenship
							United States of America

Date of Birth (MM/DD/YYYY)	Age	Social Security Number	Requested Effective Date (MM/DD/YYYY)	Date of Hire (MM/DD/YYYY)	Occupation	Salary (Annually or Monthly)

Resident Address (Number and Street, City, State, Zip – Not a PO Box)

Mailing Address (If different than resident)

Work Phone Number (w/area code)	Primary Phone Number (w/area code)	Email Address

Employer Name		MCP
Mississippi State University	Mississippi State, Mississippi	52359

SPOUSE INFORMATION (Complete only if applying for spouse coverage.)

Name (Last, First, MI, Suffix)			Country of Citizenship
NA			NA

Date of Birth (MM/DD/YYYY)	Age	Social Security Number	Gender (M/F)
NA	NA	NA	NA

BENEFICIARY

Primary Name (Last, First, MI, Suffix)	Relationship	Percentage	Product(s) (if different)

Contingent Name (Last, First, MI, Suffix)	Relationship	Percentage	Product(s) (if different)

Within the past 12 months has the applicant (or spouse if applicable) used tobacco in any form?

Applicant (Yes/No): NA

Spouse (Yes/No): NA

PRODUCT SELECTION (Benefits applied for:)

					HOME OFFICE USE ONLY			
Product	Persons Covered[1]	Plan Amount	Premium	Premium Mode	Policy Number	Plan Code	MCH	Billing Distribution ID
014405-1(14) Day								
014406-2(30) Day								
014407-3(60) Day				MONTHLY			3738	
014408-4(90) Day								
014410-5 150 Day								
TOTAL PREMIUM:			$ 0.00					

[1]z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; s=Spouse

HEALTH HISTORY	
Within the **past** 12 months has any person to be covered age 18 or older been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days (other than absences for childbirth with no complications, broken/fractured bones with full recovery or the flu)?	**Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____
Within the **past** 3 years, have you (or your spouse, if applicable) received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	**Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____
Within the **past** 3 years, have you (or your spouse, if applicable) received a diagnosis, taken medication and/or had treatment by a member of the medical profession for cancer (other than non-melanoma skin cancer)?	**Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____
Within the **past** 3 years, have you (or your spouse, if applicable) received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following: Heart and/or circulatory disease/disorder, stroke or transient ischemic attack, liver or kidney disease/disorder (other than stones), pulmonary disease (other than asthma), organ failure or transplant, systemic lupus, diabetes requiring insulin?	**Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____
Within the **past** 3 years, have you (or your spouse, if applicable) received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following: peripheral vascular disease (PVD), alcohol or drug addiction or abuse, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn's disease, disorder of blood cells or blood clotting disorder, seizures, Chronic Fatigue Syndrome (CFS), fibromyalgia, Amyotrophic Lateral Sclerosis (ALS), neurological disorder (other than headaches or migraines), schizophrenia, schizoaffective disorder, major depressive disorder, manic depressive disorder, bipolar disorder, panic disorder, psychotic disorder, agoraphobia, or post-traumatic stress disorder?	**Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____
Within the past 12 months: (a) have you (or your spouse, if applicable) had surgery recommended that has not yet been performed or received a referral for surgery consultation? (b) have you (or your spouse, if applicable) received psychiatric counseling or treatment, or received a referral or recommendation for psychiatric counseling or treatment?	**Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____ **Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____
Within the **past** 3 years, have you (or your spouse, if applicable) received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following: high blood pressure requiring 3 or more prescriptions taken concurrently, chronic pancreatitis, Hepatitis B, C, or D?	**Applicant** (Yes/No): _____ **Spouse** (Yes/No): _____

SIGNATURE AND ACKNOWLEDGEMENT

ELECTION: I hereby enroll, add or change, as selected above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay.

ACKNOWLEDGMENT: I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
- If applying for disability income coverage, **OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**
- "Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any. I further understand that any increase in coverage must be applied for and approved by the Company, and as explained in my Certificate, a new Pre-Existing Condition period will apply with respect to the increase.

I have received and reviewed a copy of the following consumer brochure form number(s): SB - 30257 - 0915

I have also received and reviewed the outline of coverage, if applicable, and any other state mandated forms *required at the time of application.*

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

I understand the following signature is acceptance and acknowledgement for each policy that is applied for under this application.

Applicant Signature or PIN		Date
011718	David R Jenkins	
Agent #	Print Agent Name (if any)	
Agent Signature or PIN (if any)		Date

A1292

Help Us Help the Environment

Electronic delivery of policy documents can offer you access to the most up-to-date documents keeping them safe so that you can have access to them at any time.

If you would like to receive and manage your American Fidelity Assurance Company Policy Documents online electronically, please read the Consent to Electronic Delivery of Policy Documents and place your initials in the space provided below.

Consent to Electronic Delivery of Policy Documents

I hereby request and agree to Electronic Delivery of Policy Documents ("Consent"), if available, by American Fidelity Assurance Company (AFA).

Policy Documents
I understand that: (1) Policy Documents will be hosted on a secure Web site; (2) I will receive an e-mail from AFA to the e-mail address that I have designated below containing instructions and AFA's web address; (3) Electronic Delivery is in lieu of regular U.S. Mail delivery; (4) Electronic Delivery is sufficient to meet all requirements under the Policy; (5) paper copies of any and all electronically delivered Policy Documents are available to me upon my request; and (6) if I have executed more than one Consent, only my last election will be in effect.

Systems Requirements
I understand that in order to receive Policy Documents electronically, I must use a valid e-mail address, an Internet connection, and a computer that meets the following minimum requirements: Internet Explorer 6.0 or later and Adobe® Reader® 8.0 or newer, available free on www.afadvantage.com or www.adobe.com.

Revocation of Consent
I understand that either party may revoke this Consent unilaterally at any time with ten (10) days prior notice to the other party. The Certificateholder/Policy Owner may revoke by calling, toll-free: 1-800-654-8489; or by writing to: American Fidelity Assurance Company, 9000 Cameron Parkway, Oklahoma City, Oklahoma 73114-3701. Upon revocation of this Consent, AFA will communicate all future Policy Documents via regular U.S. Mail to the last known designated address of the Certificateholder/Policy Owner.

Transmittal of Policy Documents
I understand that I am responsible at all times, as the Certificateholder/Policy Owner, to notify AFA in writing of any and all changes associated with the transmittal of Policy Documents. That I, as the Certificateholder/Policy Owner, agree that I will hold AFA harmless with respect to any and all delivery errors caused by my failure to provide current and valid information for the receipt of Policy Documents.

By initialing in the box below, I ☐ **agree** ☐ **do not agree** to the Electronic Delivery of my Policy Documents.

INITIAL ABOVE	DATE

Name and designated electronic transmittal e-mail address of the Certificateholder/Policy Owner:

PRINTED NAME	E-MAIL ADDRESS

American Fidelity Long Term Disability Enrollment Form Instructions

Applicant Information:

- Enter name- last/first/MI
- Enter Gender
- Enter date of birth
- Enter Age
- Enter social security number
- Enter requested effective date
- Enter date of hire
- Enter occupation
- Enter annual salary
- Enter Resident address- street/city/state/zip. NO PO BOX
- Enter mailing address if different than resident
- Enter work phone number
- Enter primary phone number
- Enter email address

Beneficiary information:

- Enter primary name- last/first/MI
- Enter relationship
- Enter percentage
- Enter contingent(secondary) beneficiary name if desired- last/first/MI
- Enter relationship
- Enter percentage

Product selection:

- Select which Plan you would like to enroll in from the following-

14day, 30day, 60day, 90day.

- Enter “Z” for persons covered
- Enter plan amount
- Enter premium

Page 2- You do not have to provide Health History if you are enrolling during your initial hiring period.

Signature and acknowledgement: Page 3

- Enter applicant signature and date

Page 4:

- Consent to Electronic Delivery of Policy Documents
- Check box if you “agree” or “do not agree” to electronic delivery of Policy documents
- Initial and date
- Enter printed name and email address if electing electronic transmittal

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