

GROUP APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N. Classen Blvd Oklahoma City, Oklahoma 73106

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1. PROPOSED INSURED INFORMATION:

Last Name _____ First Name _____ Full Middle Name _____ Suffix _____

Age _____ Date of Birth MM/DD/YYYY _____ Sex M F SSN _____ Requested Effective Date MM/DD/YYYY _____ Date of Employment MM/DD/YYYY _____

Residence Address: Number & Street (Not a P.O. Box) _____ Work Phone # () _____ Home Phone # () _____

City _____ State _____ Zip _____ Country of Citizenship _____

Mailing Address (if different than Residence) _____ City _____ State _____ Zip _____

Employer Name _____ Employer/MCP # _____ Salary: \$ _____ Occupation _____
City of Plano _____ 46192 _____ Annual Monthly

Are you currently able to perform the duties of your occupation? Yes No

Spouse Last Name _____ First Name _____ Middle Initial _____ SSN _____ Date of Birth _____ Country of Citizenship _____

Has any adult to be covered used any form of nicotine in the last 12 months? Applicant Yes No Spouse Yes No

Applicant's Email Address:

2. BENEFITS APPLIED FOR:

Product	New/Change	Persons Covered ¹	Plan Code	Plan Amount
GAP			018089-G1	\$ 500
GAP			018090-G2	\$1,000
GAP			018092-G4	\$1,500

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

3. BENEFICIARY: Last Name _____ First Name _____ Middle Initial _____ Relationship _____ Country of Citizenship _____

4. 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.

5. 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.

6. FRAUD NOTICE: Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud.

BROCHURE(S) # SB-8109T-1013 **HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S).**

Applicant Signature or PIN _____ Date _____

Agent # 80004A Agent Signature or PIN _____
(where required by law)