Reset Form

GROUP APPLICATION

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

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: $ _____ Annual ☐ Monthly ☐ | Occupation

City of Plano | 46192

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 Plan	☐ ☐		018430-GTX	$ 500
GAP Plan	☐ ☐		018431-GTX	$1,000
GAP Plan	☐ ☐		018433-GTX	$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 # 02110A Agent Signature or PIN _____
(where required by law)

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