Master Application for Group Insurance to:
AmFirst Insurance Company
Administrative Office:
5722 I-55 North Frontage Road • Jackson, MS 39211
or P.O. Box 14067 Jackson, MS 39236
Telephone: (800) 800-1397

The Information provided by the Applicant in this Application will be the basis on which any insurance is issued. Incorrect Information could void Insurance.

Applicant	Employer Identification Number
Name of Business or Organization Principal Business or Activity	SIC Code
Physical Address: (Street Number and Name) City State Zip	Billing Address: (If different from Physical Address) City State Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:

Eligibility

Eligible Person: **If enrollment is voluntary** 1. [A full time employee of the Policyholder who normally works twenty (20) or more hours per week at the Policyholder's place of business and who is under the age of sixty-five; or; 2. The employee's dependent spouse who is under the age of 65; or 3. The employee's unmarried dependent children, as defined in the General Policy Definitions, who are under the age of nineteen (age twenty-five if a full time student at an accredited school). 4. Employee who is age 65 and over if there are 20 are more employees. 5. An individual eligible for Continuation Coverage as defined by the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), or any state continuation coverage law.]	**Eligible Person:** **If employer participates in paying the premiums** 1. [An employee of the Policyholder who is insured by the employer's major medical plan; 2. An employee's dependent spouse or unmarried dependent children who were insured by the Employer's major medical plan. 3. An individual eligible for Continuation Coverage as defined by the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), or any state continuation coverage law.]

Insurance Applied For

AF-GAP-P-OK (0304) Group Accident Plan

Does a Major Medical Plan or Comprehensive Health Plan cover all Eligible Persons? __☐ Yes __☐ No
Important Note: Any person who is not insured by a Major Medical Plan or Comprehensive Health Plan is not eligible for insurance under this policy form. Minimum number of applications per group is 5.

Is this a voluntary enrollment or is the employer paying part of the premium? _____
Employer will pay _____% of Employee Costs and_____% of Dependent Costs_____

What is the Major Medical Deductible Amount $_____
What is the Major Medical Co-Insurance Out of pocket Amount _____ %_____?

Group Accident Plan Design

1 [CALENDAR YEAR]
2. REQUESTED EFFECTIVE DATE_____
3. SUPPLEMENTAL DEDUCTIBLE [PER PERSON PER CALENDAR YEAR] $ _____
4. SUPPLEMENTAL CO-INSURANCE %_____ $_____ OUT OF POCKET [PER PERSON PER CALENDAR YEAR]

BENEFITS
Plan Design Code_____ (Attach Flier Describing Benefits)

RIDERS
1.GENERIC OUTPATIENT PRESCRIPTION DRUG RIDER YES____NO____
2. BRAND AND GENERIC OUTPATIENT PRESCRIPTION DRUG RIDER YES____NO_____
3. OUTPATIENT PHYSICAL EXAMINATION AND WELLNESS RIDER YES____ NO_____
4. ALLIED SERVICE RIDER YES____ NO____
5. CREDIT FOR PRIOR PLAN DEDUCTIBLE RIDER YES____ NO_____
6. EXCLUSION EXCEPTION RIDER YES____ NO_____

Payroll and Billing Information (Check All That Apply) For Normal Payday, Give Day of Week (Monday, Friday, etc.)

_____☐ Weekly Normal Payday: _____	__☐ Bi-Weekly (Every other Week) Normal Payday: _____
_____☐ Semi-Monthly (Twice per Month) Normal Pay Dates: _____ and _____ day of the month.	__☐ Monthly Normal Pay Date: _____ day of the month.
_____☐ Other: _____	Billings must be: __☐ Alphabetic __☐ Numeric by Social Security Number __☐ Numeric by Employee Number

"WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any Company, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information is guilty of a felony."

ALL PREMIUMS ARE PAYABLE IN ADVANCE OF THE EFFECTIVE DATE OF INSURANCE.

On behalf of the Applicant, this Application for Group Insurance is signed by

X _____Print Name _____

Official Title _____, this _____ day of _____