Application for
The Galaxy Plan

AmFirst Insurance Company

Administered by
INTERNATIONAL
A division of Morgan White Group

3191 Coral Way, 7th Floor
Miami, Florida 33145

Applicant Information ❑ Individual ❑ Group

	First Name	M.I.	Last Name	Sex	Date of Birth			Age	Height (ft/inch)	Weight (lbs)
					Day	Mth	Year			
Primary										
Spouse										
Child #1										
Child #2										
Child #3										
Child #4										
Child #5										

Permanent Residence (Including City & Country)	Mailing Address	Home Telephone
Employer or other postal address:	Email:	
	Phone Number :	
Occupation and duties:		Fax:
Spouse's occupation and Employer:		

	Applicant	Optional Coverage*	Premium
1			$
2			$
3			$
4			$
5			$

Frequency of Payment

❑ Annual ❑ Semi Annual ❑ Monthly

Deductible

Mode of Payment

❑ Check ❑ Credit Card ❑ Wire Transfer

$15.00 fee applies for wire transfer • When paying by Credit Card, please complete Credit Card authorization section.

Annual Premium
Monthly (x0.092 + $2.00):
Semi Annual (x0.55):

Please provide customer number if you are an existing client.

Customer Number:

** Additional premium required. Kindly refer to current Rate Table.*

Credit Card Authorization

Name as it appears on the credit card:

Billing Address:

❑ VISA ❑ MASTERCARD ❑ AMERICAN EXPRESS ❑ DINERS ❑ DISCOVER

Credit Card Number:	Amount to be charged:
__ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __ Expiration Date: ____ /____	US $ _____

I, the undersigned, authorize MWG International, to debit from this credit card the above specified amount, related to the insurance premium. I understand that each year, in order to renew my policy, I will need to provide a new credit card authorization form. In addition, I acknowledge, that failure to provide such authorization form may result in cancellation of my policy.

Signature_____ Date _____ /_____ /_____
Day Month Year

Payments by Check

Please make checks payable to MWAII Premium Trust.

Family or personal physician's information

Name:	Name:
Address:	Address:
Telephone number:	Telephone number:

*Optional Life Coverage and Beneficiary Designation**

Primary Applicant Coverage: ❑ $10,000 ❑ $25,000 ❑ $30,000	*Spouse Coverage:* ❑ $10,000 ❑ $25,000 ❑ $30,000	**Children ($10,000 each):** ❑ Child #1 ❑ Child #2 ❑ Child #3 ❑ Child #4 ❑ Child #5 ❑ Child #6
Primary Applicant Beneficiary:	*Spouse Beneficiary:*	
In the event of the death of any insured, after the policy has been issued, I direct the Company to make payment of any money due the beneficiary as follows:		
Name:	**Name:**	
Date of Birth:	Date of Birth:	
Address:	Address:	
Phone:	Phone:	

If additional space is required for further beneficiary designations, please attach a separate page providing above requested information and the percentage share for each. If you do not name a beneficiary, the life insurance Coverage Amount will be paid to your estate.

****If purchasing the life rider with the Galaxy Plan, the Group Term Life Application must also be completed and submitted.***

Eligibility: Height & Weight Chart

Height		Weight			
Feet/Inches	Meters	Pounds/lbs		Kilograms	
		Min	Max	Min	Max
4'8"	1.42	74	173	33.57	78.47
4'9'	1.45	77	180	34.93	81.65
4'10'	1.47	79	186	35.83	84.37
4'11"	1.50	82	193	37.19	87.54
5'0"	1.52	85	199	38.56	90.26
5'1"	1.55	88	206	39.92	93.44
5'2"	1.57	91	213	41.28	96.62
5'3"	1.60	94	220	42.64	99.79
5'4"	1.63	97	227	44.00	102.97
5'5"	1.65	100	234	45.36	106.14
5'6"	1.68	103	241	46.72	109.32
5'7"	1.70	106	249	48.08	112.94
5'8"	1.73	109	256	49.44	116.12
5'9"	1.75	112	264	50.80	119.75
5'10"	1.78	115	271	52.16	122.92
5'11"	1.80	119	279	53.98	126.55
6'0"	1.83	122	287	55.34	130.18
6'1"	1.85	126	295	57.15	133.81
6'2"	1.88	129	303	58.51	137.44
6'3"	1.91	133	312	60.33	141.52
6'4"	1.93	136	320	61.69	145.15
6'5"	1.96	140	328	63.50	148.78
6'6"	1.98	143	337	64.86	152.86
6'7"	2.01	147	346	66.68	156.94
6'8"	2.03	151	355	68.49	161.03
6'9"	2.06	154	363	69.85	164.65

Eligibility	
Persons who are less than seventy (70) years old and their dependent(s) who: 1) have NOT been diagnosed or treated for the following conditions: Down's Syndrome, Autism, Epilepsy, seizure, paralysis of any kind, Alzheimer's Disease, dementia, any degenerative neurological disorder, Multiple Sclerosis, Cerebral Palsy, Lou Gehrig's disease, Sickle Cell Anemia, Cystic Fibrosis, Parkinson's disease, Diabetes Mellitus Type II with Hypertension, Crohn's Disease, hemophilia, HIV Infection or AIDS, Lupus, chronic renal insufficiency or failure, Schizophrenia, Rheumatoid Arthritis, Chronic Obstructive Pulmonary Disease (COPD), hereditary and congenital disorders or sicknesses, alcohol or substance abuse or treatment of either 2) Have a weight and height within the underwriters' weight and height chart per the policy application 3) Are not permanent residents of the United States of America.	*All persons to be insured under this coverage, have read, and understand, they meet the parameters of the "Height and Weight" and "Eligibility" located on this page.* ❑ ***Yes*** ❑ ***No***

Applicant's Statement

I hereby certify all responses and declarations contained in this application are true, complete and correct and I understand and agree any inaccuracy or omission in responses will constitute grounds for the insurer to deny a claim, invalidate or cancel any of the insurance coverage applied for. In the event the insurer cancels or otherwise invalidates the insurance coverage applied for as a result of the failure to fully disclose past medical history or Pre-existing conditions, the insurer reserves the right to recover from the applicant all costs and fees incurred in reasonably investigating those matters not fully disclosed.

I understand the broker, agent or agency receiving this application does not have the authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and all information requested in the application must be set forth in writing on this application. I further understand this application will become part of the insurance policy to be issued and the insurer will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand the broker, agent or agency taking this application from me is an independent representative and is acting on my behalf and not the administrator nor the insurance company offering this insurance. Neither the administrator nor the company offering this insurance can be held liable for any circumstance if the broker, agent or agency, who is taking this application, fails now or in the future to transmit or communicate any documentation or funds from the administrator to me and/or any documentation or funds from me to the administrator.

It is understood the insurance applied for shall not become effective until this application is approved and accepted by the insurer, full payment of the first premium is made, and the policy issued, subject to all conditions and restrictions contained therein. I understand this policy is not available to permanent residents of the United States or others who reside in the United States. However, if any applicant for coverage, who is accepted and insured by the insurer in the applicant's country of residence, moves to the United States of America, the insurer will provide an option to continue insurance coverage.

Signature of Proposed Applicant _____ Date _____ /_____ /_____
Day Month Year

Signature of Applicant's Spouse _____ Date _____ /_____ /_____
(if to be insured) Day Month Year

Pre-existing Conditions/Commencement of Benefits and Waiting Periods

Pre-existing Conditions: means any condition or consequence related to a medical condition, sickness or accident for which medical advice, consultation, diagnosis, care or treatment was received, or medications prescribed or taken, within seven (7) years prior to the effective date of this policy or its reinstatement or; (2) a condition that would have caused a prudent person to seek medical advice, consultation, diagnosis, care or treatment prior to the Individual effective date of this policy; or 3) a condition for which medical advice, consultation, diagnosis, care or treatment or any obvious symptom thereof which, if presented to a physician would have resulted in an attempt to diagnose the condition producing the symptoms prior to the effective date of this policy; or 4) any covered charges or covered services for pregnancy within twelve (12) months after the effective date of coverage under this policy.	*I understand the coverage for Pre-existing conditions for this policy.*
Commencement of Benefits and Waiting Periods: Covered benefits for the costs of any medical condition, resulting from accident or contagious diseases become payable on the effective date of the policy. No benefits will be payable for the costs of any other medical condition which manifests itself within one hundred and twenty (120) days after the effective date of the policy. Maternity is not a covered benefit under this policy.	❑ *Yes* ❑ *No*

Medical Authorization

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.) or other organization, consumer reporting agency, insurance or reinsuring company, institution or person having any record or knowledge of me or my health, including any member of my family, to give to the insurer offering the insurance, any reinsurer or its legal representative any and all such information. The nature of the information authorized to be disclosed includes information about all medical evaluation, care, treatment, diagnosis or consultation provided to the undersigned insured, or my dependents. I understand the information obtained by use of this authorization will be used by the insurer offering the insurance, and its reinsurers to determine eligibility. I direct that a copy of this authorization shall be given the same force and effect as the original. This authorization shall remain valid as long as this policy is in force.

Signature of Proposed Applicant _____ Date _____ /_____ /_____
Day Month Year

❑ For electronic delivery of policy documents, including ID cards, check this box and provide email address below.

Email address: _____

I personally solicited and completed this application as given or the answers were made by the proposed insured in his or her own handwriting.
All medical and non-medical questions were asked of each proposed insured and their answers were recorded as given.

Agent Signature / Witness: _____ Agent Code: _____

Agent Email: _____ Date: _____

Mail completed, signed enrollment form to:

MWG International
3191 Coral Way, 7th Floor • Miami, Florida 33145
Tel: (305) 422-0899 • Fax: (305) 422-0961 • Email: marketing@morganwhiteintl.com

For any additional information please refer to www.morganwhiteintl.com