Application for Group Accident Limited Benefit Insurance to:

AmFirst Insurance Company

Administrative Office:

5722 I-55 North Frontage Road • Jackson, MS 39211

or P.O. Box 14067 Jackson, MS 39236

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

Legal Name of Employer (include d/b/a):	Employer Identification Number
Principal Business or Activity	SIC Code
Physical Address: (Street Number and Name)	Billing Address: (If bill is to be split and sent to more than one billing address please indicate here and give addresses on an attached sheet.)
City	City
State Zip	State Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:
Email Address:	Email Address:
Fax Number	Fax Number

Employer's Major Medical or Comprehensive Plan Data

Major Medical Plan Carrier _____

Major Medical Deductible Amount $_____

Major Medical Coinsurance %_____ to Maximum Out of pocket (Coinsurance Limit) Amount $ _____

Are Major Medical Deductibles & Coinsurance per Plan Year or per Calendar Year? _____

Major Medical Plan Anniversary Date _____

Number of Covered: Employees _____ Dependent Spouses_____ Dependent Children_____

Eligibility

Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:

Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee)
[All active full time employees working 18 hours or more per week and who are under the age seventy will be eligible for coverage. Each insured will be eligible for Dependent coverage on the later of the following dates:
1. The day the insured becomes eligible for insurance;
2. or The day the Insured acquires his or her first dependent]

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.] Eligible new employees or dependents may be added subject to the terms of the Policy.

{Eligible Classes: _____}

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the Termination of Coverage Provisions of the Policy.

Insurance Applied For

Employer Contribution ___**{Premium Saver Plan}** ___ **{HSA Saver Plan}** ____ **{Med Bridge Plan}**
Voluntary (Employee Paid Plans) ____ **{Med Bridge Plan}**

Employer will pay _____% or $_____ of Employee Costs and_____% or $_____ of Dependent Costs

{Important Note: All persons (100 % participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be covered on Employer Contribution plans listed above.

Plan Design Selection

ATTACH FLIER OR PROPOSAL THAT DESCRIBES THE SPECIFIC BENEFITS

Applicable to {all} {Accident}{Sickness}{Inpatient}{and}{Outpatient} Benefits {Only}

Deductible: $_____ Coinsurance: _____% Out-of-Pocket Maximum (Coinsurance Limit) $_____

Maximum Total Benefit Amount $_____

Per Year Benefit Maximum Basis: ☐ **Plan Year** ☐ **Calendar Year**

Comments _____

ACCIDENT BENEFIT

{Co-payment Amount $_____} {Per visit}

Maximum Benefit Amount All Covered Facilities per Year: $_____

Maximum Benefit Amount for In-Hospital Confinement per Year $_____

Maximum Benefit Amount All Covered Outpatient Facilities per Year: $_____

OPTIONAL RIDERS

{Sickness Benefit Rider:} {☐Yes ☐ No}

{Co-payment Amount $_____} {Per visit}

{Maximum Benefit Amount All Covered Facilities per Year: $_____**}**

{Maximum Benefit Amount for In-Hospital Confinement per Year $_____}

{Maximum Benefit Amount All Covered Outpatient Facilities per Year: $_____}

{Hospital Indemnity Sickness Benefit Rider} {☐Yes ☐No}

{Outpatient Physicians Expense Rider} {☐Yes ☐ No}

{Ambulance Benefit Rider} {☐Yes ☐ No}

{Generic Outpatient Prescription Drug Rider} {☐Yes ☐ No}

{Brand {and Generic} Prescription Drug Rider} {☐Yes ☐ No}

{Outpatient Physical and Wellness Examination Rider} {☐Yes ☐ No}

{Outpatient Diagnostic Test and Lab Rider} {☐Yes ☐ No}

{Allied Services Rider} {☐Yes ☐ No}

{Prior Plan Deductible Credit Rider} {☐Yes ☐ No}

Policy/Certificate Delivery

Send Policy & Certificate to? _____Agent _____Employer

Payroll and Billing Information

{Billing is alphabetical -12 monthly Premiums}
Effective date can be {the 1st or the 15th of the month}

Make check payable to AmFirst Insurance Company.
$_____ Amount of Attached Check.

ALL PREMIUMS ARE PAYABLE IN ADVANCE. THE FIRST PREMIUM MUST BE PAID PRIOR TO THE EFFECTIVE DATE OF INSURANCE.

Agreements, Representations and Understanding

I represent that all statements made herein are complete and true as of the date I signed this Application, and I understand that AmFirst Insurance Company (AmFirst) will rely on these statements and this information as the basis for approving this Application.

I understand that the Group Accident Insurance Policy for which I have applied is a limited benefit Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy's limitations and exclusions, if any.

I understand that only those employees and dependents covered under our company's major medical or comprehensive health plan are eligible for coverage.

Check One
{I **represent** that {100%} of eligible employees and dependents will be enrolled in the plan}. _____
{I **represent** that this plan will be offered on a voluntary basis} _____

I understand that coverage is effective when: a) the Policy is issued by AmFirst; b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by AmFirst.

{We agree to make any necessary payroll deductions for any employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums and any applicable administrative fee due under the insurance Policy issued.}

I understand that the Policyholder or AmFirst may terminate the Policy and any Rider(s) on any premium due date by giving at least {90} days written notice to the other party. The Policyholder is responsible for notifying the Insureds of the termination or non-renewal of the Policy.

I understand that AmFirst and the Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

I represent that the information herein is true and complete, as of the date I signed this Application, and that I have read and understand this form.

{I acknowledge and understand that any misrepresentation on this Application by my agent or me may result in the cancellation or rescission of any Policy issued based on this Application.}

{**I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this Application for the Policyholder's state of domicile.**}

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

X _____Print Name _____

Official Title _____ this _____ day of _____

Agent Name (print)_____ Signature_____

{**FRAUD WARNING NOTICE**	
{**For residents of all states** (except the following)}	{Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.}
{**Arkansas**}	{Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}
Colorado}	{It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.}
{**District of Columbia**}	{Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.}
{**Florida**}	{Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.}
{**Kentucky**}	{Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.}
{**Louisiana**}	{Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}
{**Maine**}	{It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.}
{**Nebraska**}	{Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.}
{**New Jersey**}	{Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.}
{**New Mexico**}	{Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.}
{**Pennsylvania**}	{Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.}
{**Tennessee**}	{It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.}}

Provider Questionnaire

MorganWhiteAdministrators, (TPA for the Group Accident Plan) wants to go the extra mile to insure that you and your customers are happy with their policy.

Please list below the hospitals that you feel your client will be using. MorganWhiteAdministrators will send a letter to each of these hospitals explaining: who we are, that you just wrote a group in their area, how the Plan works, how to file a claim and who to contact if they need help or have questions.

Name of Group_____
Agent's Name _____
Agent's phone # _____

Name of Hospital	Address	Phone #

Other providers you want us to contact
