Application for Group Accident Limited Benefit Insurance to:

AmFirst Insurance Company

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 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; or
2. 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.}

Fraud Warning: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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__________ __________________________

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
