GROUP APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N. Classen Blvd Oklahoma City, Oklahoma 73106

1. PROPOSED INSURED INFORMATION: Last Name | First Name | Full Middle Name | Suffix

Age | Date of Birth Mo Day Yr | Sex M ☐ F ☐ | Soc Sec Number | Requested Eff Date Mo Day Yr | Date of Employment Mo Day Yr

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: CITY OF PLANO | Employer/MCP #: 46192 | Salary: $ Annual ☐ Monthly ☐ | Occupation

Are you currently able to perform the duties of your occupation? Yes ☐ No ☐

Applicant's E-mail Address:

2. BENEFITS APPLIED FOR:

Product	New/Chg	Billing Distribution ID	* Persons Covered[1]	Plan Code	Plan Amount	PREMIUM: Employee	Employer	Mode	Total
GAP	☐ ☐			018089-G1	$500				
GAP	☐ ☐			018090-G2	$1000				
GAP	☐ ☐			018092-G4	$1500				
	☐ ☐								
	☐ ☐								
	☐ ☐								
	☐ ☐								
	☐ ☐								
									TOTAL

* [1]z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; ~~s=Spouse~~

3. BENEFICIARY:
First Name | Middle Name | Last Name | Relationship to Insured | Country of Citizenship

4. ELECTION: I hereby enroll, add or change, as checked 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 (first page and, if applicable, the second page) 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.
- **BROCHURE(S) # SB-6736(TX)-0112 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).** (Please initial): ☐

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. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents 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. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)

AGENT SIGNATURE (where required by law) _____ Date _____

Agent # **80004A** SIGNATURE (Applicant) _____

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