RESET

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 MM/DD/YYYY | Sex M ☐ F ☐ | SSN | Requested Effective Date MM/DD/YYYY | Date of Employment MM/DD/YYYY

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 | Employer/MCP # | Salary: $_____ Annual ☐ Monthly ☐ | Occupation

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

Spouse Last Name | First Name | Middle Initial | SSN | Date of Birth | Country of Citizenship

Has any adult to be covered used any form of nicotine in the last 12 months? Applicant Yes ☐ No ☐ Spouse Yes ☐ No ☐

Applicant's Email Address:

2. BENEFITS APPLIED FOR:

Product	New/Chg	Billing Distribution ID	MCH	Persons Covered[1]	Plan Code	Plan Amount	PREMIUM: Employee	Employer	Mode	Total
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[1]z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; s=Spouse TOTAL

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

4. ELECTION: I hereby enroll, add or change, as selected 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 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. I further understand that any increase in coverage must be applied for and approved by the company, and as explained in my Certificate, a new Pre-Existing Condition period will apply with respect to the increase.

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.

BROCHURE(S) # _____ **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).**

Applicant Signature or PIN _____ Date _____

Agent # _____ Agent Signature or PIN (where required by law) _____

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PROPOSED INSURED'S NAME:

HEALTH HISTORY

	Applicant	Spouse
7. Within the **past 5** years, have you (or your spouse, if applicable) received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following: Heart and/or circulatory disease/disorder, stroke or transient ischemic attack, liver or kidney disease/disorder (excluding stones), pulmonary disease, peripheral vascular disease (PVD), organ failure or transplant, systemic lupus, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), or alcohol or drug addiction or abuse?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
8. If you are applying for Group Disability Income or Group Hospital Indemnity coverage: Within the **past 5 years**, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following: Cancer (other than basal or squamous cell skin cancer), rheumatoid arthritis, diabetes requiring insulin, epilepsy, ulcerative colitis, Crohn's disease, disorder of blood cells or blood clotting disorder, seizures, Chronic Fatigue Syndrome (CFS), fibromyalgia, Amyotrophic lateral sclerosis (ALS), neurological disorder (excluding headaches or migraines), schizophrenia, schizoaffective disorder, major depressive disorder, manic depressive disorder, bipolar disorder, panic disorder, psychotic disorder, agoraphobia, or post-traumatic stress disorder?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
9. If you are applying for Group Disability Income or Group Hospital Indemnity coverage: **(a)** Within the **past 12 months**, have you: Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received treatment (including, but not limited to, spinal manipulation, physical therapy, or counseling) for a condition related to: (1) your back, neck or spine; or (2) had surgery recommended that has not yet been performed or received a referral for surgery consultation?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
(b) Within the **past 12 months**, have you: Received psychiatric counseling or treatment, or received a referral or recommendation for psychiatric counseling or treatment?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
(c) Are you currently pregnant?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
10. If you are applying for Group Critical Illness coverage: Within the **past 10 years**, have you (or your spouse, if applicable) received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following: chronic pancreatitis**,** high blood pressure requiring 3 or more prescriptions taken concurrently**,** hepatitis B, C, or D, or diabetes?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
11. If you are applying for Group Cancer coverage: **(a)** Within the **past 10 years**, have you (or your spouse, if applicable) received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, melanoma, or a malignant tumor in any form, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
(b) Have you (or your spouse, if applicable) received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

I hereby certify that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

Applicant Initials or PIN: _____