AMERICAN FIDELITY

Please complete the disability/and or cancer application form attached as appropriate. Return completed form to American Fidelity:

- Via email: Scan and email to Donna.Sciulara@AmericanFidelity.com
- Via fax: Attention to Donna Sciulara, 866-233-3525
- Via mail: Donna Sciulara, % American Fidelity, 3505 E Flamingo Rd, Suite 6, Las Vegas, NV 89121

Call if you have questions about the coverage or about completion of the form:

702-433-5333, extension 0
Terri or Tamara can help

AMERICAN FIDELITY ASSURANCE COMPANY

9000 Cameron Parkway Oklahoma City, OK 73114

INDIVIDUAL APPLICATION

APPLICANT INFORMATION

Name (Last, First, MI, Suffix) | **Gender** (M/F) | **Country of Citizenship**

Date of Birth (MM/DD/YYYY) | **Age** | **Social Security Number:** | **Requested Effective Date** (MM/DD/YYYY) | **Date of Hire** (MM/DD/YYYY) | **Occupation** | **Salary** (Annually/ Monthly)

-01-

Resident Address (Number and Street, City, State, Zip – Not a PO Box)

Mailing Address (if different than resident)

Work Phone Number (w/area code) | **Primary Phone Number** (w/area code) | **Email Address**

Employer Name
NV SYSTEM OF HIGHER EDUCATION

MCP
80980

SPOUSE INFORMATION

(Complete only if applying for spouse coverage. Spouse will include your domestic partner as defined by State law.)

Name (Last, First, MI, Suffix) | **Country of Citizenship**

Date of Birth (MM/DD/YYYY) | **Age** | **Social Security Number** | **Gender** (M/F)

BENEFICIARY

Primary Name (Last, First, MI, Suffix) | **Relationship** | **Percentage** | **Product(s)** (if different)

Contingent Name (Last, First, MI, Suffix) | **Relationship** | **Percentage** | **Product(s)** (if different)

REPLACEMENT INFORMATION

Is the insurance applied for intended to replace or change any coverage you now have with us?

Cancer: (Y/N)_____ Accident: (Y/N) N/A Other: (Y/N) N/A

Is the insurance applied for intended to replace or change any coverage you now have with another Company?

Cancer: (Y/N)_____ Accident: (Y/N) N/A Other: (Y/N) N/A

NOTE: A person may be covered by only one American Fidelity Assurance Company individual product of similar coverage.

PRODUCT SELECTION (Benefits applied for:)

Product	Persons Covered[1]	Plan Selected/ Plan Code /Amount	Premium	Premium Mode	HOME OFFICE USE ONLY Policy Number	MCH	Billing Dist ID#
AO-03 Base Basic, Enhanced, Enhanced Plus							
Upgrade – Ben Enh Rider							
Acc Dis Income Rider							
C1106, C12D06, C12M06 – Level 1, 2, 3, 4				M		2794	STND
Cancer Rider – CI Heart				M		2794	STND
Cancer Rider – CI Cancer				M		2794	STND
Cancer Rider – ICU				M		2794	STND
Cancer Rider – FOB							
Other							
		TOTAL PREMIUM:					

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

HEALTH HISTORY

(Any person who answers "Yes" will be excluded from applicable coverage)
(Not applicable if applying for Accident coverage)

Within the past 3 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: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	**Applicant** (Yes/No) **Spouse** (Yes/No)
Within the past 3 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 cancer (other than non-melanoma skin cancer)?	**Applicant** (Yes/No) **Spouse** (Yes/No)

SIGNATURE AND ACKNOWLEDGEMENT

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 Policy is issued.

Accident Only: I understand that no Accident Only benefits will be paid for any loss that occurs while participating in: any sport for pay or profit; any contest of speed in a power driven vehicle for pay or profit; parachuting; bungee jumping; rappelling; mountain climbing or hang gliding. I understand that benefits for Accident Only will only be paid for a Covered Accident that occurs on or after the Effective Date.

I have received and reviewed a copy of the following consumer brochure form number(s): SB-30641-0217

I have also received and reviewed the outline of coverage, if applicable, and any other state mandated forms required at the time of application.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

I understand the following signature is acceptance and acknowledgement for each policy that is applied for under this application.

Applicant Signature or PIN	Signed At	Date
Agent #	Print Agent Name (if any)	
Agent Signature or PIN (if any)		Date