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

Reset

GROUP INSURED APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY

9000 Cameron Parkway Oklahoma City, Oklahoma 73114

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) -01-	Date of Hire (MM/DD/YYYY)	Occupation	Salary (Annually or Monthly)

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	MCP
NSHE - UNLV	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)

Within the past 12 months has the applicant (or spouse if applicable) used tobacco in any form?

Applicant (Yes/No): _____

Spouse (Yes/No): _____

PRODUCT SELECTION (Benefits applied for:)

					HOME OFFICE USE ONLY			
Product	Persons Covered[1]	Plan Amount	Premium	Premium Mode	Policy Number	Plan Code	MCH	Billing Distribution ID
DISAB	Z			M		014295-1	2794	STND
TOTAL PREMIUM:			$0.00					

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

HEALTH HISTORY	
Within the **past** 12 months has any person to be covered age 18 or older been absent from work due to illness or medical treatment for a period of more than 5 consecutive working days (other than absences for childbirth with no complications, broken/fractured bones with full recovery or the flu)?	Applicant (Yes/No): _____ Spouse (Yes/No): N/A
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): N/A Spouse (Yes/No): N/A
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): N/A Spouse (Yes/No): N/A
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: Heart and/or circulatory disease/disorder, stroke or transient ischemic attack, liver or kidney disease/disorder (other than stones), pulmonary disease (other than asthma), organ failure or transplant, systemic lupus, diabetes requiring insulin?	Applicant (Yes/No): N/A Spouse (Yes/No): N/A
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: peripheral vascular disease (PVD), alcohol or drug addiction or abuse, rheumatoid arthritis, 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 (other than headaches or migraines), schizophrenia, schizoaffective disorder, major depressive disorder, manic depressive disorder, bipolar disorder, panic disorder, psychotic disorder, agoraphobia, or post-traumatic stress disorder?	Applicant (Yes/No): N/A Spouse (Yes/No): N/A
Within the past 12 months: (a) have you (or your spouse, if applicable) had surgery recommended that has not yet been performed or received a referral for surgery consultation? (b) have you (or your spouse, if applicable) received psychiatric counseling or treatment, or received a referral or recommendation for psychiatric counseling or treatment?	Applicant (Yes/No): N/A Spouse (Yes/No): N/A Applicant (Yes/No): N/A Spouse (Yes/No): N/A
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: high blood pressure requiring 3 or more prescriptions taken concurrently, chronic pancreatitis, Hepatitis B, C, or D?	Applicant (Yes/No): N/A Spouse (Yes/No): N/A

SIGNATURE AND ACKNOWLEDGEMENT

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.

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.

I have received and reviewed a copy of the following consumer brochure form number(s): SB-24489-1212

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

Help Us Help the Environment

Electronic delivery of policy documents can offer you access to the most up-to-date documents keeping them safe so that you can have access to them at any time.

If you would like to receive and manage your American Fidelity Assurance Company Policy Documents online electronically, please read the Consent to Electronic Delivery of Policy Documents and place your initials in the space provided below.

Consent to Electronic Delivery of Policy Documents

I hereby request and agree to Electronic Delivery of Policy Documents ("Consent"), if available, by American Fidelity Assurance Company (AFA).

Policy Documents
I understand that: (1) Policy Documents will be hosted on a secure Web site; (2) I will receive an e-mail from AFA to the e-mail address that I have designated below containing instructions and AFA's web address; (3) Electronic Delivery is in lieu of regular U.S. Mail delivery; (4) Electronic Delivery is sufficient to meet all requirements under the Policy; (5) paper copies of any and all electronically delivered Policy Documents are available to me upon my request; and (6) if I have executed more than one Consent, only my last election will be in effect.

Systems Requirements
I understand that in order to receive Policy Documents electronically, I must use a valid e-mail address, an Internet connection, and a computer that meets the following minimum requirements: Internet Explorer 6.0 or later and Adobe® Reader® 8.0 or newer, available free on www.afadvantage.com or www.adobe.com.

Revocation of Consent
I understand that either party may revoke this Consent unilaterally at any time with ten (10) days prior notice to the other party. The Certificateholder/Policy Owner may revoke by calling, toll-free: 1-800-654-8489; or by writing to: American Fidelity Assurance Company, 9000 Cameron Parkway, Oklahoma City, Oklahoma 73114-3701. Upon revocation of this Consent, AFA will communicate all future Policy Documents via regular U.S. Mail to the last known designated address of the Certificateholder/Policy Owner.

Transmittal of Policy Documents
I understand that I am responsible at all times, as the Certificateholder/Policy Owner, to notify AFA in writing of any and all changes associated with the transmittal of Policy Documents. That I, as the Certificateholder/Policy Owner, agree that I will hold AFA harmless with respect to any and all delivery errors caused by my failure to provide current and valid information for the receipt of Policy Documents.

By initialing in the box below, I ☐ **agree** ☐ **do not agree** to the Electronic Delivery of my Policy Documents.

INITIAL ABOVE	DATE

Name and designated electronic transmittal e-mail address of the Certificateholder/Policy Owner:

PRINTED NAME	E-MAIL ADDRESS