

GROUP APPLICATION

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

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1. PROPOSED INSURED INFORMATION:

Last Name		First Name		Full Middle Name		Suffix	
Age	Date of Birth Mo Day Yr	Sex M <input type="checkbox"/> F <input type="checkbox"/>	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 COLLIERS INTERNATIONAL		Employer/MCP # 86146	Salary: \$ Annual <input type="checkbox"/> Monthly <input type="checkbox"/>	Occupation			
Are you currently actively at work and able to perform the duties of your occupation?							Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant's E-mail Address:

2. BENEFITS APPLIED FOR:

Product	New/Chg	Billing Distribution ID	Persons Covered ¹	Plan Code	Plan Amount	Employee	PREMIUM:		
							Employer	Mode	Total
STD	<input type="checkbox"/>	STND	Z	017931-D2				M	
CA	<input type="checkbox"/>								
	<input type="checkbox"/>								
	<input type="checkbox"/>								
	<input type="checkbox"/>								

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

3. BENEFICIARY:

First Name	Middle Name	Last Name	Relationship to Insured	Country of Citizenship
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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; to the best of my knowledge and belief, 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" diagnosed or treated before this coverage takes effect may not be covered; and I should read my Certificate for a more detailed explanation of the pre-existing exclusion, if any.
- BROCHURE(S) # SB-16116T HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR FOR ONLINE ENROLLMENTS, 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 # _____ SIGNATURE (Applicant) _____

PROPOSED INSURED'S NAME: _____

7. HEALTH HISTORY:

Within the **past 10 years**, have you received a diagnosis or been treated by a member of the medical profession for any of the following?

a. Cancer (other than basal or squamous cell skin cancer), heart disease, peripheral vascular disease (PVD), stroke, blood disorder, liver or kidney disorder/disease (excluding stones), pulmonary disease, insulin-dependent diabetes, rheumatoid arthritis, epilepsy, or seizures. **Yes** **No**

b. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV). **Yes** **No**

c. Chronic Fatigue Syndrome (CFS), fibromyalgia, degenerative disc disease of back or neck and/or other disorders of the back or neck, alcohol or drug addiction or abuse, psychiatric illness, or neurological disease (excluding headaches or migraines). **Yes** **No**

8. Within the **past 12 months**, have you been recommended for surgery or medical treatment that has not yet been performed? **Yes** **No**

9. Are you currently pregnant? **Yes** **No**

10. I hereby certify that: I have read the above statements and all of the medical conditions or they have been read to me; and the above statements are true and complete to the best of my knowledge and belief.

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 or void the coverage within the contestable period if such misrepresentation materially affects the acceptance of the risk.

(Please initial): _____