

**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 <b>COLLIERS INTERNATIONAL</b>		Employer/MCP # <b>86146</b>	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 <sup>1</sup>	Plan Code	Plan Amount	Employee	PREMIUM:		
							Employer	Mode	Total
STD	<input type="checkbox"/>	STND	Z	017931-D3				M	
All	<input type="checkbox"/>								
Other	<input type="checkbox"/>								
States	<input type="checkbox"/>								
	<input type="checkbox"/>								

<sup>1</sup>z=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-16117T 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): \_\_\_\_\_