GROUP DISABILITY APPLICATION

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

PROPOSED INSURED

Last Name (maiden name) First Name Full Middle Name Suffix

Age | Date of Birth Mo Day Yr | Sex M ☐ F ☐ | Soc Sec Number | Requested Eff Date Mo Day Yr | Date of Employment Mo Day Yr

Number and Street | Work Phone # ( ) | Home Phone #

City | State | Zip | State of Birth

Employer | MCP # | Salary $ Annual [x] Monthly ☐ | Occupation

Austin ISD | **33593**

Do you now have or have you ever had any other coverage with us? Yes ☐ No ☐
If so, write the existing Customer Number in the box in the upper right corner.

Product	A/C[1]	MCH #	Payor #	Benefits Applied For: Plan	Amt	Mode	Employee Prem	Employer Prem	Total
Disability	☐	**1387**	**33593**			**M**		**xxx**	
	☐							**xxx**	
[1]A=Add C=Change						Totals:		**xxx**	

MEDICAL INFORMATION

1. Within the past 10 years, have you received a diagnosis, had treatment, and/or taken medication for: Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Immunodeficiency disorder, Rheumatoid Arthritis, Fibromyalgia, Chronic Fatigue Syndrome, Lung Disease, Emphysema, Tuberculosis, Ulcerative Colitis, Crohn's Disease, Diabetes requiring Insulin, Heart or Circulatory disorder, Cancer or other malignancy, Organ Transplant, Systemic Lupus Erythematosus, Epilepsy, Seizures, Neurological disorder, Blood Clotting disorder, Alcohol treatment, Drug use, Liver disorder, or Kidney disease? _____
2. Within the past 12 months, have you received a diagnosis, had treatment, and/or taken medication for: (a) back or neck disorder; (b) mental or nervous disorder; or (c) had surgery recommended that has not yet been performed? _____
3. Are you currently pregnant? _____

Please initial the following:

☐ I have not been treated for any of the above conditions.

BENEFICIARY

First Name Full Middle Name Last Name Suffix Relationship to Insured

AUTHORIZATION

I hereby enroll, add or change, as checked above, group disability coverages for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay. **ANY CHANGE REQUIRES WRITTEN NOTICE.** To the best of my knowledge and belief, the statements and answers shown in this application are true and complete. I understand and agree: a) that the Company may rely upon such answers as the basis of my contract and eligibility for benefits; and b) that no coverage will take effect until a Policy or Certificate is issued. I understand that: "pre-existing conditions" are generally not covered under the coverage(s) applied for. I should read my Certificate for a more detailed explanation of the pre-existing exclusion or limitation, if any. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by the Company. **I UNDERSTAND THAT OTHER INCOME I AM ENTITLED TO RECEIVE WILL REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**

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

_____ Date _____
AGENT (where required by law)

Agent # **Self Enrollment**

_____
SIGNATURE (Applicant)

A1200