



**AFA INSURANCE**

## enrollment form instructions

1. **Complete the Enrollment Form** Type in the blue fields on the PDF form, or print the form and write in your information in ink. Be sure to sign and date the form.
2. **Save a copy for your records.** Email the completed form to [SubmitApp@ftj.com](mailto:SubmitApp@ftj.com)  
or mail to : Forrest T. Jones & Company  
P.O. Box 418131  
Kansas City, MO 64141-8131

We will contact you within 10 business days to let you know if your request for coverage has been accepted or if additional information is required.

## satisfaction guaranteed

When you receive your certificate of insurance, review it carefully. If you are not completely satisfied with the terms of your coverage, simply return your certificate, without claim, within 30 days. Your coverage will be invalidated, and you'll receive a full refund, no questions asked.

## questions

Contact us by email, postal mail, or telephone.  
We will be happy to answer your questions.

**Thanks you for your interest in this valuable coverage.**



**CustomerService@  
AFAinsure.com**



**Forrest T. Jones & Company  
P.O. Box 418131  
Kansas City, MO 64141-8131**



**800.291.8480**

Administered by



3130 Broadway | P.O. Box 418131 | Kansas City, MO 64141-8131

In Arizona, Forrest T. Jones Consulting Company

**Enrollment begins on next page →**

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
One Hartford Plaza  
Hartford, Connecticut 06155  
(A stock insurance company)



## Hospital Indemnity Insurance Plan Enrollment Form

Member ages 64 or younger  
Group Policyholder: Air & Space Forces Association (AFA)  
Policy Number: AGP-5955

### Member Information

Are you a member of the Air & Space Forces Association?  Yes  No

AFA Membership Number: \_\_\_\_\_ Military Rank: \_\_\_\_\_

Member's Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Member's Social Security Number: \_\_\_\_\_ Member's Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Cell Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Is Spouse/Partner coverage desired?  Yes  No

Spouse's/Partner's Full Name (if enrolling): \_\_\_\_\_

Spouse's/Partner's Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Dependent Child(ren) information (if enrolling): \_\_\_\_\_ If more than 4 children, attach an additional sheet

CHILD(REN) NAME	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____

If more than 4 children, attach an additional sheet **Coverage Information**

**YES, enroll me in the AFA Hospital Indemnity Insurance Plan.** I understand I have 30 days to review my Certificate of Insurance at no risk.

**Age Reduction**

The benefit amount(s) payable for the Member and the Member's Spouse or Partner will decrease by 50% on the Premium Due Date on or next following the date the Member turns age 80.

Choose the coverage that is right for you:  Low coverage  High coverage

Select benefits for:  Member Only  Member Plus Spouse/Partner  Member Plus Child(ren)  Family

**Mail your enrollment form to:** Group Insurance Administrator, P.O. Box 418131, Kansas City, MO 64141-8131.

**Confirmation**

I hereby confirm my enrollment in the AFA Hospital Indemnity Plan. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be a member of AFA to be eligible for coverage. I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this Hospital Indemnity Plan will not cover pre existing conditions (conditions for which I received medical advice or treatment within 12 months until the coverage has been in effect for 12 months. I understand the above coverage will become effective on the first day of the month following receipt of my enrollment form and first premium payment. I further understand that new conditions will be covered immediately. I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's/Partner's Signature (if enrolling): \_\_\_\_\_ Date: \_\_\_\_\_

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

Coverage will be issued upon receipt of this form and will begin when your first premium is received. However, insurance benefits payable are subject to the policy's Pre-Existing Conditions Limitation. You're covered immediately for ALL new health conditions and any current health conditions you have will be covered fully after 12 months. Please refer to the enclosed brochure for more information on exclusions and limitations, such as pre-existing conditions.

**Payment Method (choose one)**

A.  **Monthly Automatic Withdrawal:**  Checking Account (include VOIDED check)  Savings Account (include Deposit slip)

I authorize my bank to deduct my insurance premium from the financial account indicated above on a monthly basis. If I wish to discontinue this authorization, or my account number changes, I will notify the plan administrator in writing.

Signature: (as it appears on account) X \_\_\_\_\_

B.  **Credit Card Billing:**  Monthly  Quarterly  Semiannually  Annually

MasterCard  VISA Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_  
MM YYYY

Print Name: (as it appears on card) \_\_\_\_\_

I authorize charges against this credit card for the purpose of collecting insurance premium payments due under this plan. If I wish to discontinue this authorization, or my credit card changes, I will notify the plan administrator in writing.

Signature: \_\_\_\_\_

C.  **Direct Bill:**  Monthly  Quarterly  Semiannually  Annually