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**
   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 certifcate, 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

ftj Forrest T. Jones & Company®

3130 Broadway I P.O. Box 418131 I 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 & Short-Term Recovery Insurance Plan Enrollment Form

Member ages 65-99
Group Policyholder: Air & Space Forces Association (AFA)
Policy Number: AGP-40016

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

Hospital Indemnity Form Series includes GBD-2800 GBD-2900; or state equivalent

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
At age 80, Home Recovery Benefits reduce to $200 a day for up to 20 days per year (one benefit period or up to $4,000 per year). The Hospital or Skilled Nursing Facility Benefits do not change regardless of age.

Select benefits for:

☐ Member ☐ Member Plus Spouse/Partner

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