

American Guild Alliance
AFI Rep Worksheet

CIGNA Plan Selection (check one):

☐ **PPO 3000**

☐ **PPO 5000**

CIGNA national network in all 50 states www.cigna.com

- ☐ **Clean, completed applications must be received by AFI by Noon on the 25th of the month prior to the requested start date.**
- ☐ **Please note that there is an annual AFI Membership fee of \$95**
- ☐ **Current Tax Documents (Schedule C, K-1, or W-2) must accompany the application**

Our address is: **47 Nepperhan Avenue, Suite #4**
 Elmsford, NY 10523

Fax is: **914-366-8063**

E-mail is: **Dave@afibenefits.net**

Member Name _____ Rep. Name _____

Member Signature _____ Rep. Signature _____

Date _____ Rep. Phone Number _(_____)_____

Please note it will take 15-20 Business days after your effective date for your ID cards to arrive from the carrier.

Member's Initials _____

AMERICANS FOR FINANCIAL INDEPENDENCE

MEMBERSHIP FORM

MEMBER INFORMATION						
MEMBER LAST NAME			MEMBER FIRST NAME			
MEMBER SS#			MEMBER DOB			
HOME PHONE			CELL PHONE			
MEMBER GENDER ☐ MALE ☐ FEMALE			EMAIL			
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER						
STREET ADDRESS						APT #
CITY			STATE		ZIP	
EMPLOYED 20+ HRS PER WEEK (ON AVERAGE) ☐ NO ☐ YES			OCCUPATION			
			☐ W2 ☐ K1 ☐ SCHEDULE C			
BUSINESS NAME			BUSINESS PHONE			
BUSINESS ADDRESS			BUSINESS EMAIL			
SPOUSE / DOMESTIC PARTNER INFORMATION (IF APPLICABLE)						
SPOUSE / PARTNER LAST NAME (IF DIFFERENT)			SPOUSE / PARTNER FIRST NAME			
SPOUSE / PARTNER SS#			SPOUSE / PARTNER DOB			
SPOUSE / PARTNER GENDER ☐ MALE ☐ FEMALE			SPOUSE / PARTNER EMAIL			
DEPENDENT INFORMATION (IF APPLICABLE)						
LAST NAME (IF DIFFERENT)	FIRST	MIDDLE	DOB	AGE	RELATIONSHIP TO MEMBER	SS #
PLAN SELECTION						
PLAN NAME		EFFECTIVE		PREVIOUS CARRIER		
*** All documents included in my application for benefits have been completed accurately and truthfully to the best of my knowledge.						
MEMBER SIGNATURE				DATE		

Personal Health Questions For Applicant and Dependents – Circle YES or NO. Must answer ALL Questions

1. Heart Attack, brain tumor, stroke, heart disease or heart problems? YES NO
2. Cancer, tumor, lymphoma or any type of transplant? YES NO
3. Any surgery or hospitalization in the last 5 years, OR currently pending, planned or recommended? YES NO
4. Emphysema or COPD? YES NO
5. Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder? YES NO
6. Seizures, epilepsy, hemophilia, Sleep Apnea or blood disorder? YES NO
7. Diabetes, endocrine, Auto Immune, Crohn's Disease or Arthritis or pituitary disorder, growth disorder, lupus, MS, AIDS or HIV+? YES NO
8. Currently pregnant, premature delivery or multiple births? YES NO
9. Is anyone listed on the application taken or are currently taking medications in the last 12 months? YES NO

If **Yes** answer to questions # 1 - 8 please provide date, type and further treatment if any.

If **Yes** answer to question # 9 list any and all **Medications** taken in the last 12 months below by anyone listed on the application.

Please list the name of medication, dosage and corresponding medical condition information. Please include diagnosis date and date of last physician visit for condition.

Applicant Signature _____ Date _____

American Guild Alliance

Effective Date _____

- Occupation – _____
- Plan Type – Circle one - Single, Husband/Wife, Parent/Child, Family
- Resident State _____
- Applicant DOB _____

Applicant Name:
Applicant Height & Weight:
Applicant Gender:
Applicant Marital Status:
Applicant Social Security #:
Within the last 12 months, has applicant had prior or no health coverage? If yes, need name of carrier, effective date <u>and</u> date of termination:
Applicant Home Address:
Applicant Contact Phone #:
Applicant Email Address:

Employer Name:
Employer Phone:
Employer Address:
Average # of Hours Worked Per Week: (Must be 30 hours or more to qualify)
Employment Start Date:
Occupation:
Compensation Type – (Circle One) Minimum Wage, Greater than Minimum Wage but less than \$10/hour, Greater than \$10/hour but less than \$20/hour, Greater than \$20/hour, Salary

FAGE MARKETING SALES

AUTHORIZATION AGREEMENT FOR PRE-ARRANGED WITHDRAWALS

This bank account deduction program allows you to have your premium automatically deducted from your bank account. Please complete and sign this form to authorize withdrawals.

Member's Name: _____
Last Name First Name

Payer's Name: _____
(if different from above)

Address: _____

INITIAL

WITHDRAWAL

Date: ____ / ____ / ____

Amount: \$ _____

RECURRING

WITHDRAWAL

Start Date: ____ / ____ / ____

Amount: \$ _____

☐ Monthly

☐ Quarterly

☐ Semi-Annual

☐ Annual

Payer's

Bank Name: _____

Routing Number: _____ **Account Number:** _____

I hereby authorize Fage Marketing Sales aka Fage Financial, to initiate withdrawal(s) from my bank account in such amount as needed to keep my benefits active until revoked. Revocation must take the form of written notification from member and/or payer in such manner to afford Fage Financial a reasonable opportunity to act on it and/or within 30 days. I understand Fage Financial may cancel this payment plan at any time. I represent and warrant that I am authorized to execute this authorization agreement and I indemnify and hold Fage Financial, bank and their agents harmless from damages, loss or claims resulting from all authorized actions hereunder.

***** Note: \$35 return fee for "non sufficient funds", \$50 return fee for "non authorized or stopped, account frozen, etc"**

Payer's

Signature: _____ **Date:** _____

Print

Name: _____ ☐ New Participant ☐ Change

ATTACH VOIDED CHECK

Acknowledgement of Late Enrollment

I acknowledge that my enrollment materials were submitted after the 20th of the month prior to the effective date of coverage.

Therefore, as a result of the delay, I understand and accept that I may not be able to verify my eligibility sooner than 30 days from the start date of enrollment.

I further understand and accept that my identification card(s) may arrive no sooner than 30 days from the requested start date of enrollment.

I also understand and accept that I may have to contact the carrier directly regarding any out-of-pocket expenses and/or claims issues.

I understand that if I need additional assistance in expediting the process mentioned above, I can contact customer service at (845) 499-2255 or gsmith@fagefinancial.com.

Signature of member

Date

____/____/____