Metro Atlanta Financial Group

Group number: _____ Requested Effective Date: ____/____/____

# Medical Application Form

Instructions: Please complete boxes outlined in **RED.**

## A: Personal Information

Last Name: _____ Middle Initial: ____ First Name: _____

Date of Birth: ___/___/____ Social Security Number: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ E-mail Address: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Gender: ◯ Male ◯ Female

Occupation: _____ Date of Hire: ___/___/____

Hours: _____ Salary: _____

## B: Dependents to be Insured (Leave BLANK if coverage is NOT elected)

**Dependent 1**

Last Name: _____ Middle Initial: ____ First Name: _____

Date of Birth: ___/___/____ Social Security Number: _____

Gender: ◯ Male ◯ Female

**Dependent 2**

Last Name: _____ Middle Initial: ____ First Name: _____

Date of Birth: ___/___/____ Social Security Number: _____

Gender: ◯ Male ◯ Female

**Dependent 3**

Last Name: _____ Middle Initial: ____ First Name: _____

Date of Birth: ___/___/____ Social Security Number: _____

Gender: ◯ Male ◯ Female

**Dependent 4**

Last Name: _____ Middle Initial: ____ First Name: _____

Date of Birth: ___/___/____ Social Security Number: _____

Gender: ◯ Male ◯ Female

## C: Acknowledgement of Coverage and Signature

Name Printed: _____

Signature: **X** _____ Signature Date: ___/___/____