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: ___/___/____