Metro Atlanta Financial Group

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

Disability 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: _____

Is the applicant currently a smoker? ○ Yes ○ No

Has the applicant used any tobacco products in the past 12 months? ○ Yes ○ No

B: Acknowledgement of Coverage and Signature

Name Printed: _____

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