

**AFA NEW BUSINESS DATA SHEET  
(TO BE COMPLETED BY THE AGENT)**

1. DATE \_\_\_\_\_ 2. REQUESTED EFFECTIVE DATE \_\_\_\_\_  
 3. SECTION 125: BEGIN PLAN YEAR DATE \_\_\_\_\_ 4. END PLAN YEAR DATE \_\_\_\_\_  
 5. WAITING PERIOD \_\_\_\_\_ 6. CASH WITH APP?  YES  NO  
 7. FIRM (MCP)# \_\_\_\_\_ 8. FIRM (MCP) NAME \_\_\_\_\_  
 9. GROUP (MCH) # \_\_\_\_\_ 10. GROUP (MCH) NAME \_\_\_\_\_  
 11. AGENT # \_\_\_\_\_ 12. AGENT OF RECORD NAME \_\_\_\_\_

13.	a. Elimination Period/Benefit Period/Amount	b. # Full Time Eligible Employees	c. # Existing Insureds	d. # New Applications	e. Employer Contribution	f. Participation Percent
Disability – STD						
Disability – LTD						
Group Life	_____ X Salary - Or - Face Amount \$ _____					
GAP PLAN™	\$ _____					
<b>Major Medical coverage must be approved and in force at the time of the requested effective date</b>						
Other						

14. Is the firm a member of an endorsed Association?  NO  YES Name of Association: \_\_\_\_\_  
 15. How many full-time employees under age 70 are working 25 or more hours per week? \_\_\_\_\_  
 16. How many part-time employees? \_\_\_\_\_ 17. How many employees are in the waiting period? \_\_\_\_\_  
**18. Takeover of Pre-Ex**  YES  NO **If yes, attach the required takeover information.**  
 19. Special Quote by Risk Management  YES  NO  
 20. Name of employee(s) that have been denied: \_\_\_\_\_  
 21. Other reasons not eligible: \_\_\_\_\_  
 22. Do you keep a signed form on record showing the employee rejected the coverage?  YES  NO  
 23. Is the firm in common ownership with another firm?  YES  NO  
 If yes, what is the name of the other firm? \_\_\_\_\_

**This plan is endorsed/sponsored by an employer or an association or issued through a trust in which the employer is a member, is intended to be covered by ERISA, and will be administered and enforced in accordance with ERISA.**

\_\_\_\_\_  
Signature of AFA Representative

\_\_\_\_\_  
Signature of Employer Representative & Title