TO ENROLL:

- Print-out and complete the attached application form
- Indicate benefit amounts desired
- Return it with the premium payment (check payable to The Hirshorn Company) to the Plan Administrator:

AFSA Desk
The Hirshorn Company
14 East Highland Avenue
Philadelphia, PA 19118-3389 U.S.A.
215-242-8200 800-242-8221
Fax: 215-247-6366

(click to) visit us on the web
(click to) send us email

You Choose the Principal Sum

ANNUAL RATE IS $1.00 PER $1,000.00 OF COVERAGE

Benefit Amount	Annual Premium per Person
$ 10,000*	$10.00
$ 50,000	$50.00
$100,000	$100.00
$150,000	$150.00
$200,000	$200.00
$250,000	$250.00
$300,000	$300.00
$350,000	$350.00
$400,000	$400.00
$450,000	$450.00
$500,000	$500.00

**$10,000 benefit is for dependent children only.*

Spouse

May be insured for any amount shown, but not for more than the amount purchased by the Member.

Child(ren)

Each dependent child may be insured for any amount up to $50,000, but not for more than the amount purchased by the Member.

AFSA Group Accident Insurance Plan

APPLICATION FORM

Name

AFSA member number

Address

City

State Zip code Country

email address

Date of birth

Beneficiary

Relationship

Amount of Insurance $ Premium $

If dependent(s) are eligible for coverage:

Spouse

Date of birth

Beneficiary

Relationship

Amount of Insurance $ Premium $

PLEASE NOTE: If you designate your wife as beneficiary, show her as **Mary Jones Smith,** not as Mrs. John A. Smith. You may designate “Estate” if you desire. Coverage becomes effective on the **FIRST** day of the month following acceptance of application.

Child’s Name

Date of birth

Beneficiary

Relationship

Amount of Insurance $ Premium $

Child’s Name

Date of birth

Beneficiary

Relationship

Amount of Insurance $ Premium $

Total Premium Remitted $

Member’s Social Security Number

Signature of Eligible Member X

Date