Employer Transfer Form

Customer Information

Customer Number: _____

Customer Name: _____

Phone Number: _____

SSN: _____

Previous Employer Information

MCP Name: _____

MCP Number: _____

Last Deduction Date: _____

New Employer Information

MCP Name: _____

MCP Number: _____

Effective Date of Transfer: _____

First Deduction Date: _____

Number of Deductions: _____

Would you like to continue all of your coverage with American Fidelity?

Yes No

If no, please specify the coverage you would like to continue.

_____

_____

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

American Fidelity
Billing Administration
PO Box 25523
Oklahoma City, OK 73125-0523
Telephone: 800-662-1113
Email: WG-BillAdmin@americanfidelity.com