

American Floral Industry Association

is now offering to all members

Association Health Programs

Health Insurance

Individual
Group-full & part-time employees
Student Plans
Short-Term Coverage
Medicare Supplements
International Travel Insurance

Long-Term Care Insurance

Home Care
Assisted Living Care
Nursing Home Care

Life Insurance

Term
Universal
Survivorship (2nd to Die)
Key Person
Executive Benefit Life

Dental & Vision

Disability Income

Critical Illness

Accident & Cancer Policies

Supplemental Insurance

Accident/Sickness Disability
Critical Illness
Short Term Disability
Group Travel/Accident
Cancer Expense Protection
Accidental Death Dismemberment
Intensive Care Policy
Hospital Confinement Policy
Short Term Travel Insurance
Term Life Policy
International Travel Insurance
Discount Prescription Cards
Volunteers/Students Traveling Abroad

Retirement, Financial & Estate Planning

Health Savings Accounts, Cafeteria Plans, 105B's

Association Services, Inc.

Marketing & Graphic Design
Website Design
Internet Services & Search Engines
Digital Printing & Trade Show Signs
Paperless Document Imaging
Xerox Authorized Color Copiers

AFIA Association Health Programs

6319 West 110th Street, Overland Park, KS 66211

Call us toll free at **(888) 450-3040**

Visit us at **www.associationpros.com/assoc/AFIA**

Email us at **help@associationpros.com**

Fax us at **(913) 341-2803**

**Receive enhanced insurance benefits for yourself, your
family, or your employees (both full and part-time)!**

AFIA Association Health Programs Quote Request

<input type="checkbox"/> Health	<input type="checkbox"/> Life	<input type="checkbox"/> Long-Term Care	<input type="checkbox"/> Disability
<input type="checkbox"/> Cancer/Accident	<input type="checkbox"/> Dental	<input type="checkbox"/> Other _____	

Member Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
County: _____ Email: _____
Phone: _____ Fax: _____

Current Insurance

Carrier: _____ Current Premium: _____
Deductible: _____ Maximum Out of Pocket: _____
Office Visit Copay: _____ Prescription Copay: _____

Primary Insured Information

Date of Birth: _____ Age _____
Gender: M F Tobacco User: Yes No
Height: _____ Weight: _____

Spouse Information

Date of Birth: _____ Age _____
Gender: M F Tobacco User: Yes No
Height: _____ Weight: _____

Number of Children to be Insured: _____

Does any member of the family take any prescription medications?

Yes No If yes, please answer:

Who? _____ Medication/Diagnosis: _____

Has any member of the family been treated for Heart Disease, Diabetes, Cancer, Stroke, High Blood Pressure, or any other medical condition?

Yes No If yes, please answer:

Who/When? _____ Diagnosis/Treatment: _____

Is any member of the family currently pregnant? Yes No

To Receive A Proposal or Talk to a Licensed Agent in Your State:

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Vist us at www.associationpros.com!

