CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION
Please Mail: PO Box 84078,
Columbus, GA 31993
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Critical Illness		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY				
☐ **Initial Enrollment**	☐ **New Hire**	☐ **Re-Enrollment**	☐ **New Eligible**	☐ **Re-Submission**

Deduction start date _____

Applicant Name (First, MI, Last)		Social Security # or ID #		Gender	Date of Birth
Street Address		City		State	ZIP
Group Policyholder **Central DeWitt Community Schools #24405**		Class/Occupation	Location	Date of Hire	
E-mail address (optional)		Hours Worked per Week	Daytime Phone No.		
Spouse's Name (if coverage is requested)			Spouse's Gender	Spouse's Date of Birth	

	Applicant	**Spouse**
Are you actively at work?	☐ **YES** ☐ **NO**	
Have you used tobacco products in the last 12 months?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

LIST ALL ELIGIBLE CHILDREN FOR WHOM YOU ARE PROPOSING COVERAGE (FROM YOUNGEST TO OLDEST):

Name	**Gender**	**Date of Birth**	**Name**	**Gender**	**Date of Birth**

Beneficiary Information – Employee's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

Beneficiary Information – Spouse's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

GROUP ACCIDENT INSURANCE ☐ New Coverage ☐ Change in Coverage ☐Increase/Buy-Up
☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family
Cost per pay period: $_____

This form is not complete unless signed and dated as indicated.

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage ☐Increase/Buy-Up

☒ With Cancer ☒ Health Screening Benefit

Applicant Face Amount: $	Applicant cost per pay period: $
Spouse Face Amount: $	Spouse cost per pay period: $
	TOTAL cost per pay period: $

STATEMENT OF INSURABILITY

COMPLETE FOR GROUP CRITICAL ILLNESS INSURANCE AMOUNTS REQUESTED ABOVE GUARANTEE ISSUE AMOUNT

		Applicant	Spouse
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐YES ☐NO	☐YES ☐NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma of the skin.	☐YES ☐ NO	☐YES ☐NO
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) High blood pressure, resulting in your now taking 3 or more medications for treatment?	☐YES ☐NO	☐YES ☐NO

HEALTH COVERAGES:

- Does this coverage replace any existing Aflac individual policy? ☐ **YES** ☐ **NO**
  If **yes**, please identify which product: ☐ Critical Illness ☐ Accident

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.

ALL COVERAGES:

If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify the company.

To the best of my knowledge and belief, my answers to the questions are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect unless I am actively at work on the effective date of coverage, and until my application is approved and the necessary premium is paid. If I am not actively at work on the effective date of coverage, coverage will become effective on the date I return to an active work status.

I understand and agree that the coverage I am applying for may have a pre-existing condition limitation.
I authorize the Group Policyholder to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.
I certify that I am actively at work. If applicable, I certify to the best of my knowledge and belief that my spouse is not currently disabled or unable to work. If applicable, I certify to the best of my knowledge and belief that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.

A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an application or filing a claim that contains any false or deceptive statement.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____

Agent's Printed Name_____

Agent No._____ State of Enrollment_____
Agent's certification: To the best of my knowledge, I certify this policy will not replace or change any existing life insurance policy(ies). I have provided the applicant with the required accelerated benefit disclosures.