Aflac

CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail: Post Office Box 427
Columbia, South Carolina 29202
(800) 433-3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Term Life		

Endorsement:

EFFECTIVE DATE:

Applicant Name/Owner (First, MI, Last)	S.S.N./ ID Number	Gender	Date of Birth

Street Address	City	State	Zip

Employer	Job Class	Location	Date of Hire
Franklin County Schools #20509			

Hours Worked	Daytime Phone No. ( )	Beneficiary Name / Relationship

Spouse's Name (if coverage is requested)	Gender	Spouse Date of Birth	Spouse's Beneficiary/Relationship

	Employee	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

TERM LIFE **Base Plan: ☐ 10 year, ☐ 20 year, ☐ 30 year**

Coverage: ☐ Employee Face Amount:_____ Premium:_____

☐ Spouse Face Amount:_____ Premium:_____

☐ Children Face Amount:_____ Premium:_____

	Section I - Complete for Modified Guarantee Issue	**Applicant**	**Spouse**	**Children**
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2	In the last twelve (12) months, have you missed more than five (5) consecutive days of work due to illness or injury other than pregnancy, flu, strained or sprained muscle or fractured limb?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	[illegible] Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

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This application is not complete unless signed and dated on the back

4	Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a 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) now taking 3 or more medications for high blood pressure?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
5	Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

If you answered <u>Yes</u> to any question for Child Coverage, indicate name of Child/Children

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**
- If "Yes," provide carrier and policy number:_____

CERTIFICATION: I have read the completed application and 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 until my application is approved and the necessary premium is paid.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

I understand and agree that there may be underwriting done at the time of application for this insurance.

I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance.

Deduction start date_____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date_____ Signature of Applicant _____ State of Enrollment _____
I, the agent, have truly and accurately recorded on this enrollment form the information supplied by the insured.

Date_____ Signature of Agent _____ Agent #_____