CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION

Please Mail: Post Office Box 84078
Columbus, GA 31993-9102
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Critical Illness		
Hospital Indemnity		

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 **Vance County Government #22759**	Class Occupation	Location	Date of Hire
E-mail address	Hours Worked per Week	Daytime Phone No.	
Spouse's Name (if coverage is requested)		Spouse's Gender	Spouse's Date of Birth
Beneficiary Name/Relationship (estate unless designated otherwise)			

	Applicant	**Spouse**
Are you actively at work?	☐ YES ☐ NO	
Is your spouse now disabled or unable to 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

GROUP ACCIDENT INSURANCE ☒ 24 Hour Plan: High

☐ New Coverage ☐ Change in Coverage

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

Cost per pay period: Including any Riders $_____

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage

With Cancer: ☒ no With Health Screening Benefit: ☒ yes

☒ Optional Benefits Rider ☒ Heart Event Rider ☒ Additional Benefits Rider ☒ TIA 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**
4	Have you ever received any treatment or consultation for: any disorder of the central nervous system, Parkinson's disease, Alzheimer's disease, dementia, senility, or organic brain syndrome?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
5	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

GROUP HOSPITAL INDEMNITY INSURANCE ☐ New Coverage ☐ Change in Coverage

Plan: ☐ 1 $500 (Low), ☐ 2 $1500 (High)

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

Cost Per Pay Period Including any Riders: _____

If <u>NOT</u> Guaranteed Issue, answer the following questions:

		Applicant	**Spouse**	**Children**
1	Have you ever been treated or diagnosed by a medical professional 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 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.	☐ **YES** ☐ **NO**	☐ **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**	☐ **YES** ☐ **NO**
4	Have you ever sought treatment by a licensed medical professional 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**

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 any existing Aflac individual policy? ☐ **YES** ☐ **NO**
  If **yes**, please identify which product: ☐ Critical Illness ☐ Accident ☐ Hospital Indemnity ☐ Dental ☐ Disability
- Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**
  If **yes**, provide carrier and policy number:
  _____

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.

Coverage will not become effective unless you are actively at work on the Certificate Effective Date. If you are not actively at work on that date, coverage will become effective on the date you return to an active work status.

CERTIFICATION: I have read the completed Employee Application /Statement of Insurability and the statements and answers that pertain to me and my spouse and my children. I certify that these statements and answers are true and complete to the best of my knowledge and belief, and that the statements and answers will be used by the insurance company to determine insurability. I realize any false statement or misrepresentation in the Employee Application /Statement of Insurability may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application /Statement of Insurability is approved and the necessary premium is paid.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

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. I certify that my spouse is not currently disabled or unable to work. I certify that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

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_____

I, the agent, have truly and accurately recorded on this enrollment form the information supplied by the insured.

Date_____ Signature of Agent_____

Agent's Printed Name_____

Agent No._____ State of Enrollment_____

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