CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION /STATEMENT OF INSURABILITY

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

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

FOR AGENT USE ONLY				
☐ **Initial Enrollment**	☐ **New Hire**	☐ **Re-Enrollment**	☐ **Newly 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	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 or your spouse used tobacco products in the last 12 months?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

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 CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse
❑ New Coverage ❑ Change in Coverage ❑ Increase/Buy-Up

Applicant Face Amount: $_____

Spouse Face Amount: $_____

Applicant cost per pay period: $_____
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 advice, 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**
6	Have you ever received any advice, treatment or consultation for a diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's Disease) or multiple sclerosis?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

Are you currently covered under, or does this coverage replace, an Aflac individual Critical Illness insurance policy?
☐ YES ☐ NO

If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.

I have considered all of my existing health insurance coverage with Aflac and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac at 1-800-992-3522 regarding my individual policy and for assistance in evaluating the suitability of my insurance coverage.

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 intentional 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.

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____ Agent No._____
State of Enrollment_____

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