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***
Hospital Indemnity		
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
Are you actively at work?	☐ **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%

HOSPITAL INDEMNITY

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

☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Cost per pay period: $_____

Are you currently covered under, or does this coverage replace, an Aflac individual Hospital Indemnity 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 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's Printed Name_____

Agent No._____ State of Enrollment_____

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