CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION /STATEMENT OF INSURABILITY

Please Mail To: Post Office Box 427
Columbia, South Carolina 29202
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 **Venus ISD #22776**	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 or your spouse used tobacco products in the last 12 months?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage
With Cancer: ☑ yes
With Health Screening Benefit: ☑ yes

Applicant Face Amount: $_____ **Applicant cost per pay period:** $_____

Spouse cost per pay period: $_____

Spouse Face Amount: $_____ **Total cost per pay period:** $_____

☒ Additional Benefits ☒ Progressive Diseases Rider ☒ Optional Benefits Rider

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**

Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**

If yes, provide carrier and policy number: _____

I understand and am aware that if this coverage will replace any existing individual policy, it may be in my best interest to maintain my individual guaranteed-renewable policy via direct bill. I should contact my insurance carrier for an explanation of options for both continuation or cancellation of 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. 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 intentional 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.

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 may be guilty of insurance fraud.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____Agent No._____ State of Enrollment_____

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