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***
Critical Illness		
Accident		
Endorsement:		
EFFECTIVE DATE: 1/1/2011		

Employee 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
Campbell University			

Hours Worked	Daytime Phone No. ( )	Beneficiary Name / Relationship (estate unless designated otherwise)

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

	Employee	Spouse
Are you actively at work?	☐ YES ☐ NO	
Are you now hospitalized or unable to perform your normal duties and activities?		☐ 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

Type of Coverage

1 **CRITICAL ILLNESS** ☐ Employee ☐ Employee & Spouse Section 125: ☐ Yes ☐ No

Employee Face Amount: $_____ ***Employee Cost per pay period:*** $_____

Spouse Face Amount: $_____ ***Spouse Cost per pay period:*** $_____

		Employee	Spouse
1a	Have you used tobacco products in the last 12 months?	☐ YES ☐ NO	☐ YES ☐ NO
1b	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
1c	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	☐ YES ☐ NO	☐ YES ☐ NO
1d	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

2 **ACCIDENT** X 24 Hour ☐ Non-Occupational Plan __1_____ Section 125 ☐ Yes ☐ No

☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family ***Cost per pay period:*** $_____

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

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_____

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

Date_____ Signature of Agent_____ Agent#_____State of Enrollment_____