



**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	
Accident				
Critical Illness				
Endorsement:				
EFFECTIVE DATE:				
FOR AGENT USE ONLY				
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> New Eligible	<input type="checkbox"/> Re-Submission
Deduction start date _____				

Employee Name/Owner (First, MI, Last)		Social Security Number/ID Number		Gender	Date of Birth
Street Address		City		State	ZIP
Employer <b>State of Delaware-Benefit Focus - #21408</b>		Job Class/Occupation	Location		Hire/Change of Status Date
Hours Worked	Daytime Phone Number ( )	Beneficiary Name/Relationship (estate unless designated otherwise)			
Spouse's Name (if coverage is requested)		Gender	Spouse's Date of Birth		
				Employee	Spouse
Are you currently working part-time or full-time for the employer listed above?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now disabled or unable to work?					<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you used tobacco products in the last 12 months?				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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

**ACCIDENT**     24 Hour    Plan:     High Option     Low Option

New Coverage     Change in Coverage

Employee     Employee & Spouse     Employee & Children     Family

**Cost per pay period: Including any Riders \$** \_\_\_\_\_

**CRITICAL ILLNESS**     Employee     Employee and Spouse    With Cancer:  Yes

New Coverage     Change in Coverage

**Employee** Face Amount: \$ \_\_\_\_\_    **Employee cost per pay period:** \$ \_\_\_\_\_

**Spouse** Face Amount: \$ \_\_\_\_\_    **Spouse cost per pay period:** \$ \_\_\_\_\_

		Employee	Spouse
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

To the best of my knowledge and belief, the answers to the questions on this Enrollment Form 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

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 employed part-time; full-time on the enrollment date and on the effective date.

CERTIFICATION: I have read the completed Enrollment Form and I realize any false statement or misrepresentation in the Enrollment Form may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Enrollment Form 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 my employer 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 and with intent to defraud any insurance company or any other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concealing any fact material thereto commits a fraudulent insurance act, which is a crime.**

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_ Signature of Agent \_\_\_\_\_ Agent No. \_\_\_\_\_ State of Enrollment \_\_\_\_\_



### Things to Consider Before Replacing Your Existing Insurance Coverage

Aflac’s goal is to provide you with outstanding insurance products that offer important financial protection to you and your loved ones in the event of an accident or illness. To best serve our customers, we offer a robust portfolio of products designed to respond to a variety of needs and circumstances. If you are thinking about replacing one type of policy for another, please be aware that there are important differences between insurance products—specifically group products versus individual products. These differences may affect your coverage. Before making a change to any existing coverage you may have, please make sure to carefully compare the benefits provided by your existing policy and the proposed replacement coverage. Among the items you should consider are the following:

1. If you are currently receiving treatment for an injury or illness: Your new coverage will not cover claims for treatment received as a result of injuries or illnesses diagnosed prior to its effective date.
2. If you terminate existing coverage, no benefits will be paid for diagnoses or treatments you receive after the termination date.
3. Benefits of your existing policy and the replacement coverage you’re considering may be different, and you may be subject to new waiting periods and/or coverage exclusions due to preexisting conditions.
4. If you terminate an existing policy, you will lose any accrued benefits. Any such accrued benefits cannot be transferred to new coverage.
5. Individual insurance coverage is guaranteed-renewable and cannot be cancelled for any reason other than non-payment of premium.
6. Group insurance coverage is not guaranteed-renewable. If the master policy held by your employer or organization is cancelled, your coverage terminates.
7. Individual insurance coverage is fully portable. If you leave your current job, you can retain your individual insurance coverage.
8. Group coverage has limited portability. If you change jobs, you may not be able to retain your coverage.

**By signing below, I acknowledge that I have received this notice and wish to apply for new coverage.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Applicant’s Name (printed) \_\_\_\_\_

Address (printed) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Telephone \_\_\_\_\_