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: 7/1/2014

Employee Name/Owner (First, MI, Last)	S.S.N./ ID Number	Gender	Date of Birth
Street Address	City	State	Zip
Employer **CHARLES COUNTY GOVERNMENT**	Job Class	Location	Date of Hire
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

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	In the last 7 years have you 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	In the last 7 years have you 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 ☒ 24 Hour Plan High

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

I understand that all statements made in this application shall, in the absence of fraud, be deemed representations and not warranties. 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 knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature of Applicant _____ State of Enrollment _

Date _____ Signature of Agent _____ Agent#

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