



**CONTINENTAL AMERICAN
INSURANCE COMPANY**

EMPLOYEE APPLICATION

Please Mail: Post Office Box 84078
Columbus, GA 31993-9102
800.433.3036

FOR HOME OFFICE USE ONLY				
PLAN	PLAN CODE		ID NUMBER	
Accident				
Critical Illness				
Endorsement: WRAP				
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 _____				

Applicant Name (First, MI, Last)		Social Security # or ID #		Gender	Date of Birth
Street Address		City		State	ZIP
Group Policyholder Albion College #19633		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?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Is your spouse 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

GROUP ACCIDENT INSURANCE Applicant Applicant & Spouse Applicant & Children Family
 24 Hour Plan Low Option New Coverage Change in Coverage

Cost per pay period: \$ _____

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 Face Amount: \$ _____	Spouse cost per pay period: \$ _____
TOTAL cost per pay period: \$ _____	

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)?	<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 of the skin.	<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
---	---	--	--

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 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 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 and my children. 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 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.

I certify that I am actively at work. I certify that my spouse is not currently disabled or unable to work. I certify that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____

Agent's Printed Name _____

Agent No. _____ State of Enrollment _____

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