CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION

Please Mail: P.O. Box 84078
Columbus, GA 31993 800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Critical Illness		
Hospital Indemnity		

Endorsement:

EFFECTIVE DATE:

FOR AGENT USE ONLY

☐ Initial Enrollment	☐ New Hire	☐ Re-Enrollment	☐ New 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 **Broward Health #26109**		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	
Have you used tobacco products in the last 12 months?	☐ YES ☐ NO	☐ 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

GROUP ACCIDENT INSURANCE

☑ 24 Hour Plan _____ ☐ New Coverage ☐ Change in Coverage

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

Cost per pay period: Including any Riders $_____

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage

With Cancer: ☑ yes

With Health Screening Benefit: ☑ yes

☑ Progressive Diseases Rider ☑ Occupational HIV Rider ☑ Optional Benefits Rider ☑ Additional Benefits Rider

Applicant Face Amount: $	Applicant cost per pay period: $
Spouse Face Amount: $	Spouse cost per pay period: $
	TOTAL cost per pay period: $

COMPLETE FOR GROUP CRITICAL ILLNESS INSURANCE AMOUNTS REQUESTED ABOVE GUARANTEE ISSUE AMOUNT OR IF A LATE ENROLLEE:

	Applicant	Spouse

1	To the best of your knowledge, in the last 7 years, have you tested positive for exposure to the HIV infection or been diagnosed by a licensed medical professional as having AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?	☐ YES ☐ NO	☐ YES ☐ NO
2	To the best of your knowledge, in the last 7 years, has a licensed medical professional treated you for or diagnosed you 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	To the best of your knowledge, in the last 7 years, has a licensed medical professional treated you for, or diagnosed you 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	To the best of your knowledge, in the last 7 years, have you been diagnosed by a licensed medical professional 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	To the best of your knowledge, in the last 2 years, has a licensed medical professional diagnosed you with or treated you for a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	☐ YES ☐ NO	☐ YES ☐ NO
6	To the best of your knowledge, in the last 7 years, have you been diagnosed by a licensed medical professional for amyotrophic lateral sclerosis (Lou Gehrig's disease) or multiple sclerosis?	☐ YES ☐ NO	☐ YES ☐ NO

GROUP HOSPITAL INDEMNITY INSURANCE Plan: _____ ☐ New Coverage ☐ Change in Coverage

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

☑ Base Plan (check one): ☑ Mid

☑ Employer Facility Rider

Cost Per Pay Period Including any Riders: _____

COMPLETE FOR GROUP HOSPITAL INDEMNITY INSURANCE IF A LATE ENROLLEE:

		Applicant	Spouse	Children
1	To the best of your knowledge, have you ever tested positive for exposure to the HIV infection or been diagnosed by a licensed medical professional as having AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection ?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2	To the best of your knowledge, in the last 7 years, has a licensed medical professional treated you for or diagnosed you 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.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
3	To the best of your knowledge, has a licensed medical professional treated you for, or diagnosed you 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	☐ YES ☐ NO
4	To the best of your knowledge, in the last 5 years, have you sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

- Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**
  If yes, provide carrier: _____
- Are you currently covered under, or does this coverage replace, an Aflac individual policy? ☐ **YES** ☐ **NO**
  If yes and if it is the same type of coverage you are applying for on this application, please identify which individual policy(ies) you already have: ☐ Critical Illness ☐ Cancer ☐ Accident ☐ Hospital Indemnity ☐ Disability

If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.

I have considered all of my existing health insurance coverage with Aflac and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac at 1-800-992-3522 regarding my individual policy and for assistance in evaluating the suitability of my insurance 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 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 may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application 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 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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.