CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM
Please Mail: PO Box 84078
Columbus, GA 31993-4078

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

Endorsement: Non CI Wrap

EFFECTIVE DATE:

FOR AGENT USE ONLY

☐ **Initial Enrollment** ☐ **New Hire** ☐ **Re-Enrollment** ☐ **New Eligible** ☐ **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	**Job Class/Occupation**	**Location**	**Hire/Change of Status Date**
Dickinson College #17991			

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 full-time for the employer listed above?	☐ **YES** ☐ **NO**	
Are you now disabled or unable to 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**

ACCIDENT ☒ 24 Hour Plan **High** ☐ New Coverage ☐ Change in Coverage

☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Cost per pay period: $_____

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:** $_____

Are all applicants covered by an individual or group policy that provides primary medical insurance not designed to be supplemental insurance? ☐ **YES** ☐ **NO**

Persons having no Comprehensive Health Care coverage are not eligible for this supplemental coverage.

		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)?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

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 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 other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____Agent No._____ State of Enrollment_____

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