Aflac®

CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail To: Post Office Box 427
Columbia, South Carolina 29202
800.433.3036

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

Endorsement:

EFFECTIVE DATE:

FOR AGENT USE ONLY

☐ **Initial Enrollment** ☐ **New Hire** ☐ **Re-Enrollment** ☐ **Newly Eligible** ☐ **Re-submission**

Deduction start date _____

Employee Name/Certificate Holder (First, MI, Last)	**Social Security Number/ID Number**	**Gender**	**Date of Birth**
Street Address	**City**	**State**	**ZIP**

Employer	**Job Class/Occupation**	**Location**	**Hire Date/Change of Status Date**
Wayne County Government #21582			

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**

CRITICAL ILLNESS ☐ Employee ☐ Employee and Spouse With Cancer: ☐ No ☐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)?	☐ **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**

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.

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_____

I, the agent, have truly and accurately recorded on this enrollment form the information supplied by the insured.

Date_____ Signature of Agent_____Agent No._____ State of Enrollment_____