CONTINENTAL AMERICAN INSURANCE COMPANY, a wholly owned subsidiary of Aflac Incorporated, is the insuring 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***
Hospital Indemnity		
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 Wayne County Government #21582	**Job Class/Occupation**	**Location**	**Hire/Change of Status Date**

Hours Worked	Daytime Phone Number ( )	Spouse's Name (if coverage is requested)	Gender	Spouse Date of Birth

Employee Height / Weight	Spouse Height / Weight

	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

List all eligible children for whom you are proposing coverage (from Youngest to Oldest):

Name	Gender	Date of Birth	Name	Gender	Date of Birth

HOSPITAL INDEMNITY Plan: ☐ Low (plan I) ☐ High (plan II)

☐ New Coverage ☐ Change in Coverage

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

		Employee	Spouse	Children
1	Have you ever 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	☐ 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	☐ 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	☐ YES ☐ NO
4	Have you ever 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

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**
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 part-time; full-time on the enrollment date and on the effective date.

CERTIFICATION: I certify, 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.

The undersigned applicant and agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

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 No.___________________ State of Enrollment_________
I, the agent, have truly and accurately recorded on this enrollment form the information supplied by the insured.