Aflac®
CONTINENTAL AMERICAN INSURANCE 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*
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 _____

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
USD 495 Ft Larned Schools 13024			

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 Option ☐ 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:** $_____

		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

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

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

Hospital Indemnity

☐ New Coverage ☐ Change in Coverage

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

Cost per pay period: $_____

Base Plan : ☒ Mid

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

☐Hospital Indemnity

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.

REPRESENTATION: 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_____

Date_____ Signature of Agent_____Agent No._____ State of Enrollment_____