CONTINENTAL AMERICAN INSURANCE COMPANY

Employee Enrollment Disclosures

HEALTH COVERAGE:

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.

ALL COVERAGES:

If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify the company.

I understand and agree that this coverage may have a pre-existing condition limitation.

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. If applicable, I certify to the best of my knowledge and belief that my spouse is not currently disabled or unable to work. If applicable, I certify to the best of my knowledge and belief that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.

By signing this enrollment form and providing my email address, I am agreeing to receive my certificate of insurance electronically.