Aflac

Coverage underwritten by CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail: Post Office Box 84078
Columbus, GA 31993-40778
(800) 433-3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Critical Illness		
Endorsement: Non CI Wrap		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)	SSN	Gender	Date of Birth
Street Address	City	State	Zip

Employer **Adventist Health #10102**	Job Class	Location	Date of Hire

Hours Worked	Daytime Phone No. ( )	Beneficiary Name / Relationship (estate unless designated otherwise)

*Spouse's Name (if coverage is requested)	Gender	*Spouse Date of Birth

Spouse includes Domestic Partner as defined in California Family Code Section 297.	**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 & *Spouse ☐ 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 for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC)? California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
2	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or 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 a) a stroke, a heart attack, a 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) now taking 3 or more medications for high blood pressure?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**
- If "Yes," provide carrier and policy number:_____

Does the person to be insured have comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? ☐ YES ☐ NO

Persons without such comprehensive coverage are not eligible for coverage.

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application that was made with actual intent to deceive Continental American Insurance Company may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

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 and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance.

Deduction start date_____

Any person who knowingly and with intent to defraud an insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concealing any fact material thereto commits a fraudulent insurance act, which is a crime.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____ Agent #_____ State of Enrollment_____