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		
Disability Income		
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**
Tata Consultancy Services #10437			

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 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: $_____

DISABILITY INCOME ☒ Non-Occupational Class: ☒ Select
Annual Salary $_____
☐ New Coverage ☐ Change in Coverage
Monthly Benefit Amount: *$*_____ ***Cost per pay period:*** **$**_____
Elimination Period: Accident: 7 days Sickness: 7 days Benefit Period: 3 months

If NOT Guaranteed Issue, answer the following questions:

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**
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**

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

3	Have you ever been treated for 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**
4	In the last twelve (12) months, have you missed more than five (5) consecutive days of work due to illness or injury other than pregnancy?	☐ **YES** ☐ **NO**
5	Are you taking prescription medications on a regular basis for any back, neck, knee, or shoulder condition, rheumatoid or degenerative arthritis, respiratory disease, urinary or digestive disease, immune system disease or disorder, mental or nervous disorder? (This does not include simple infections/viral infections treated short term with antibiotics)	☐ **YES** ☐ **NO**
6	Have you ever sought advice or treatment for alcohol abuse, 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**

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:
☐ Accident
☐Disability

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.

I certify that I currently work full-time for the employer listed on this Enrollment Form and that my spouse is not currently disabled or unable to work.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____Agent No._____State of Enrollment_____