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***
Hospital Indemnity		

Endorsement:

EFFECTIVE DATE:

Employee Name/Owner (First, MI, Last)	S.S.N./ ID Number	Gender	Date of Birth

Street Address	City	State	Zip

Employer	Job Class	Location	Date of Hire

Hours Worked	Daytime Phone No.	Spouse's Name (if coverage is requested)	Gender	Spouse Date of Birth

	[Employee]	Spouse
Are you actively at work?	☐ YES ☐ NO	
Are you now hospitalized or unable to perform your normal duties and activities?		☐ 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:_____ [Section 125: ☐ Yes ☐ No]

☐ [Employee] [☐ Employee & Spouse] [☐ Employee & Children] [☐ Family] ***Cost per pay period:*** $_____

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:_____

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application 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 injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____Agent#_____State of Enrollment_____