CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail: Post Office Box 427
Columbia, South Carolina29202
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Critical Illness		
Accident		
Disability		

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
School Board of Sarasota County			

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

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

Type of Coverage

1 **CRITICAL ILLNESS** ☐ Employee ☐ Employee & Spouse

Employee Face Amount: $_____ ***Employee Cost per pay period:*** $_____

Spouse Face Amount: $_____ ***Spouse Cost per pay period:*** $_____

Only answer the questions below if you are applying for a benefit amount higher than the base amount.		**Employee**	**Spouse**
1a	Have you used tobacco products in the last 12 months?	☐ YES ☐ NO	☐ YES ☐ NO
1b	Has any person to be insured tested-positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐ YES ☐ NO	☐ YES ☐ NO
1c	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
1d	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	☐ YES ☐ NO

2 **ACCIDENT** x 24 Hour Plan __High Option___

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

This application is not complete unless signed and dated on the back

5	**DISABILITY** x Non-Occupational Gross Monthly Salary $_____ Riders: _____ Monthly Benefit Amount: *$*_____ ***Cost per pay period:* $**_____ Elimination Period: Accident: __0_____ Sickness: ___7_____ Benefit Period: __3 months_____ Employee Height / Weight _____ ***If NOT Guaranteed Issue, answer the following questions.***	
5a	Has any person to be insured tested-positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐ **YES** ☐ **NO**
5b	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**
5c	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**
5d	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**
5e	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**
5f	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 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_____