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***
Life		

Endorsement:

EFFECTIVE DATE:

Employee Name/Owner (First, MI, Last)		S.S.N./ ID Number	Gender	Date of Birth
Street Address	City		State	Zip
Employer **School Board of Sarasota County #17892**	Job Class	Location		Date of Hire
Hours Worked	Daytime Phone No. ( )	Beneficiary Name / Relationship		
Spouse's Name (if coverage is requested)	Gender	Spouse Date of Birth	Spouse's Beneficiary/Relationship	

	Employee	Spouse
Are you actively at work?	☐ YES ☐ NO	
Have you used tobacco products in the last 12 months?	☐ YES ☐ NO	☐ 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

LIFE **Plan Face**

Annual Salary $_____

Coverage: ☐ Employee Face Amount:_____ Premium:_____

☐ Spouse Face Amount:_____ Premium:_____

☐ Children Face Amount:_____ Premium:_____

☐ Children Term Rider Face Amount:_____ Premium:_____

☐ Other Insured Term Rider Face Amount:_____ Premium:_____

Dollar a Week Option:

☐ Employee

☐ Spouse

** Child must be under 19, and primary insured is automatically the beneficiary.*

Employee Height / Weight	Spouse Height / Weight
Employee Driver's License State/Number	Spouse Driver's License State/Number

CA-2006-Life FL

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

		Employee	Spouse	Children
1	Have you ever 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**	☐ **YES** ☐ **NO**
2	In the last 7 years has a licensed member of the medical profession treated you for or diagnosed you 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**	☐ **YES** ☐ **NO**
3	Have you ever been treated by a licensed member of the medical profession 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**	☐ **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, which was treated or diagnosed by a licensed member of the medical profession?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
5	Are you taking prescription medications on a regular basis for 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**	☐ **YES** ☐ **NO**	☐ **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**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

If you answered <u>Yes</u> to any question for Child Coverage, indicate name of Child/Children

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 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_____ State of Enrollment_____

Agents Name_____ Agents License ID#_____