



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		
				<b>Employee</b>	<b>Spouse</b>	
Are you actively at work?				<input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you used tobacco products in the last 12 months?				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now hospitalized or unable to perform your normal duties and activities?					<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you answered Yes 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# \_\_\_\_\_