Aflac.

Coverage underwritten by
CONTINENTAL AMERICAN LIFE INSURANCE COMPANY
ENROLLMENT FORM
Please Mail: Post Office Box 84078
Columbus, Georgia 31993-4078
(800) 433-3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
Accident		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY

☐ Initial Enrollment ☐ New Hire ☐ Re-Enrollment ☐ Newly 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
SBCPOA #18933			

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

*Spouse includes Domestic Partner as defined in California Family Code Section 297.	Employee	Spouse
Are you currently working full-time for the employer listed above?	☐ YES ☐ NO	
Are you now disabled or unable to work?		☐ 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

☐ Spouse ☐ Children ☐ Family **Cost per pay period:Including any Riders$**_____

California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.

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
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 Application and I realize any false statement or misrepresentation in the Application that was made with actual intent to deceive Continental American Life Insurance Company 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.
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.

Any person who knowingly and with intent to defraud an insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concealing any fact material thereto commits a fraudulent insurance act, which is a crime.

Date:_____ Signature of Applicant_____

Date:_____ Signature of Agent_____ Agent No.:_____ State of Enrollment:_____