CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION Please Mail: PO Box 84078, Columbus, GA 31993
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Critical Illness		
Hospital Indemnity		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY				
☐ Initial Enrollment	☐ New Hire	☐ Re-Enrollment	☐ New Eligible	☐ Re-Submission
Deduction start date ________________________				

Applicant Name (First, MI, Last)		Social Security # or ID #	Gender	Date of Birth
Street Address	City		State	ZIP
Group Policyholder	Class / Occupation	Location	Date of Hire	
	Hours Worked per Week	Daytime Phone No.		
Spouse's Name (if coverage is requested)		Spouse's Gender	Spouse's Date of Birth	

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

Beneficiary Information – Employee's Beneficiary

Name	Relationship	Address	Date of Birth		Telephone #	Percent
						%
						%

Total: 100%

Beneficiary Information – Spouse's Beneficiary

Name	Relationship	Address	Date of Birth		Telephone #	Percent
						%
						%

Total: 100%

GROUP ACCIDENT INSURANCE

☐ New Coverage ☐ Change in Coverage ☐Increase/Buy-Up

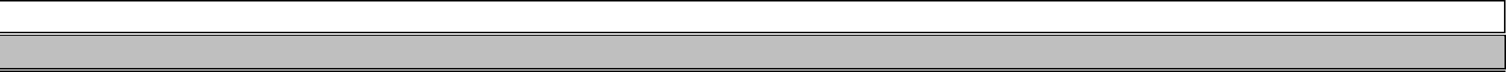
☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

Cost per pay period: $__________

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage ☐Increase/Buy-Up

Applicant Face Amount: $	Applicant cost per pay period: $
Spouse Face Amount: $	Spouse cost per pay period: $
	TOTAL cost per pay period: $



GROUP HOSPITAL INDEMNITY INSURANCE

☐ New Coverage ☐ Change in Coverage ☐ Increase/Buy-Up

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

Cost Per Pay Period: ____________________________

Are you currently covered under, or does this coverage replace, an Aflac individual policy? ☐ **YES** ☐ **NO**
If yes and if it is the same type of coverage you are applying for on this application, please identify which individual policy(ies) you already have: ☐ Critical Illness ☐ Accident ☐ Hospital Indemnity

If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.

I have considered all of my existing health insurance coverage with Aflac and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac at 1-800-992-3522 regarding my individual policy and for assistance in evaluating the suitability of my insurance coverage.
If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify the company.

To the best of my knowledge and belief, my answers to the questions are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. I realize any intentional misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect unless I am actively at work on the effective date of coverage, and until my application is approved and the necessary premium is paid. If I am not actively at work on the effective date of coverage, coverage will become effective on the date I return to an active work status.

I understand and agree that the coverage I am applying for may have a pre-existing condition limitation.

I authorize the Group Policyholder 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 presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Date____________ Signature of Applicant____

Date____________ Signature of Agent____

Agent's Printed Name____

Agent No.___________________ State of Enrollment_________
Agent's certification: To the best of my knowledge, I certify this policy will not replace or change any existing life insurance policy(ies). I have provided the applicant with the required accelerated benefit disclosures.

This form is not complete unless signed and dated as indicated.

Payment Authorization Agreement – Enhanced Billing Solution

Policyholder / Applicant Information

Group Number: __________________

Name: ______________________
Address: ______________________
City, State, ZIP: ______________________
Phone: ______________________

Policy Numbers	Premium $	Policy Numbers	Premium $
No. of policies	☐	Total: $	

Email address: ______________________________

Deduction Information

For newly issued policies only: For ease of your policy administration, we will make the effective date of coverage the same as your selected draft date following the receipt of your application in worldwide headquarters if the policy is issued.
Applicant's Initials _______

What is the deduction frequency of the **Group (Please choose one)**?

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Please provide the deduction day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Please provide the date of first deduction. ______________________________

☐ I choose to pay by electronic draft.

Draftee Name: ______________________
Depository Name/Branch: ______________________
City: ______________________ State: ______________ ZIP: ______________
Transit/ABA Number: ______________________
Account Number: ______________________ ☐ Checking ☐ Savings

☐ I choose to pay by credit or debit card.

☐ Visa ☐ Credit card ☐ MasterCard ☐ Debit card ☐ American Express

Card Number: ______________________ Expiration Date: ______________ CVV Code (back of card): _________

Confirmation / Authorization

I hereby authorize Aflac ("Company") to initiate debit entries to the deposit account designated above, at the financial institution ("Financial Institution") named above, using the Automated Clearing House ("ACH") or other payment transfer service chosen by Company from time to time. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until Company has received written notification from me of its termination in such time and in such manner as to afford Company and the Financial Institution a reasonable opportunity to act on it. I represent that (i) the credit or debit card ("Card") information provided above is accurate; and (ii) that I own the account (or have legal authority to use the account) being accessed by the Card provided. I understand and agree that Aflac will continue to initiate recurring debit entries or charges to the Card account beyond the expiration date of the Card and will automatically update the Card information as necessary to continue initiating debit entries or charges.

Account Holder's/Card Holder's Signature:
(If different from Policyholder/Applicant) ______________________ Date: __________

Policyholder's/Applicant's Signature: ______________________ Date: __________

Agent's Signature:
(Required for SNG Only) ______________________ Writing Number: ___________ Date: ______________

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters ● 1932 Wynnton Road ● Columbus, GA 31999-0001
1.800.99.AFLAC. (1.800.992.3522) ● aflac.com