



**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:		

HEALTH COVERAGES: THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

**EFFECTIVE DATE:**

FOR AGENT USE ONLY				
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> New Eligible	<input type="checkbox"/> 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 <b>City of Boulder #24628</b>	Class/Occupation	Location	Date of Hire	
E-mail address (optional)	Hours Worked per Week	Daytime Phone No.		
Spouse's Name (if coverage is requested)		Spouse's Gender	Spouse's Date of Birth	
			<b>Applicant</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

**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	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

**Beneficiary Information – Spouse's Beneficiary**

Name	Relationship	Address	Date of Birth	Social Security #	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: \$
	<b>TOTAL</b> cost per pay period: \$

**STATEMENT OF INSURABILITY**

**COMPLETE FOR GROUP CRITICAL ILLNESS INSURANCE AMOUNTS REQUESTED ABOVE GUARANTEE ISSUE AMOUNT**

		<b>Applicant</b>	<b>Spouse</b>
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma of the skin.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, 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) High blood pressure, resulting in your now taking 3 or more medications for treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	Have you ever received any advice, treatment, or consultation for: any disorder of the central nervous system, Parkinson's disease, Alzheimer's disease, dementia, senility, or organic brain syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	Have you ever received any advice, treatment or consultation for a diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's disease) or multiple sclerosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**GROUP HOSPITAL INDEMNITY INSURANCE**

New Coverage    Change in Coverage    Increase/Buy-Up  
 Applicant    Applicant & Spouse    Applicant & Children    Family

**Cost Per Pay Period :** \_\_\_\_\_

If **NOT** Guaranteed Issue, answer the following questions:

		<b>Applicant</b>	<b>Spouse</b>	<b>Children</b>
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<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, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a 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 for, or diagnosed with, any of the following: a) Stroke, heart attack, 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) High blood pressure, resulting in your now taking 3 or more medications for treatment?	<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 5 years, have you 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

**HEALTH COVERAGES:**

- Does this coverage replace any existing Aflac individual policy?  YES  NO  
If **yes**, please identify which product:  Critical Illness  Accident  Hospital Indemnity  Dental  Disability

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.

**ALL COVERAGES:**

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 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 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.

If applicable, I certify to the best of my knowledge and belief that my spouse is not currently disabled or unable to work. If applicable, I certify to the best of my knowledge and belief that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.**

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.**