**CONTINENTAL AMERICAN INSURANCE COMPANY**

**Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated, is the insuring company.**

**EMPLOYEE APPLICATION**

Please Mail: P.O. Box 84078
Columbus, GA 31993
800.433.3036

| FOR HOME OFFICE USE ONLY | | |
|---|---|---|
| ***PLAN*** | ***PLAN CODE*** | ***ID NUMBER*** |
| ***Accident*** | | |
| ***Critical Illness*** | | |
| ***Disability Income*** | | |
| ***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 **New Kent County #25239** | | Class Occupation | Location | Date of Hire | |
| E-mail address | | Hours Worked per Week | Daytime Phone No. | | |
| Spouse's Name (if coverage is requested) | | | Spouse's Gender | Spouse's Date of Birth | |
| Beneficiary Name/Relationship (estate unless designated otherwise) | | | | | |

| | 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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**GROUP ACCIDENT INSURANCE**

☒ 24 Hour Plan _____ ☐ New Coverage ☐ Change in Coverage

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

**Cost per pay period: Including any Riders** $_____

**GROUP CRITICAL ILLNESS INSURANCE** ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage

With Cancer: ☒ yes With Health Screening Benefit: ☒ yes Waiver of Premium: ☒ yes ☒Heart Event Rider ☒ Additional Benefits Rider

| | |
|---|---|
| Applicant Face Amount: $ | Applicant cost per pay period: $ |
| Spouse Face Amount: $ | Spouse cost per pay period: $ |
| | **TOTAL** cost per pay period: $ |

**STATEMENT OF INSURABILITY**

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

| | | Applicant | Spouse |
|---|---|---|---|
| 1 | Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? | ☐ YES ☐ NO | ☐ YES ☐ NO |



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| | | | |
|---|---|---|---|
| 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. | ☐ YES ☐ NO | ☐ YES ☐ NO |
| 3 | Have you ever been treated for, or diagnosed with, any of the following:<br>a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder;<br>b) Kidney (renal) failure or end stage kidney (renal) disease;<br>c) Organ transplant;<br>d) Emphysema; or<br>e) High blood pressure, resulting in your now taking 3 or more medications for treatment? | ☐ YES ☐ NO | ☐ YES ☐ NO |

**GROUP DISABILITY INCOME INSURANCE** ☐ **New Coverage** ☐ **Change in Coverage**

**If you answer "no" to the following questions, you will not be eligible for coverage:**

| | |
|---|---|
| Are you currently working full-time for at least 30 hours per week for the Employer listed above? | ☐ YES ☐ NO |
| Do you earn at least $9,000 base annual pay working for your Employer, the Policyholder? | ☐ YES ☐ NO |

| | | | |
|---|---|---|---|
| **Class:** ☒ **B** | **Elimination Period:** | Accident: 0 | Sickness: 7 |
| ☒ **24-Hour** | **Benefit Period:** | ❑ 3 month ❑ 6 month | |
| | **Monthly Benefit Amount:** | $ | |
| **Annual Salary:** $ | **Cost per pay period:** | $ | |

| | | |
|---|---|---|
| | Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation, or a similar law in your job with the Employer listed on this application? | ☐ YES ☐ NO |
| | If you are a resident of California, Hawaii, New Jersey, New York, or Rhode Island, are you covered by your state's Temporary Disability Insurance (TDI) or an equivalent state disability insurance plan? (If you are not a resident of any of these states, please mark no). | ☐ YES ☐ NO |
| 1 | What is your current height and weight? | _____**ft.** _____**in.**<br>_____**lbs.** |
| 2 | Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? | ☐ YES ☐ NO |
| 3 | In the last 2 years have you been diagnosed, received medical advice, sought treatment (including surgery), or taken medication for any of the following:<br>a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder;<br>b) Kidney (renal) failure or end stage kidney (renal) disease;<br>c) Organ transplant;<br>d) Emphysema;<br>e) High blood pressure, resulting in your now taking 3 or more medications for treatment; **or**<br>f) 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.) | ☐ YES ☐ NO |
| 4 | In the past 12 months, have you for any reason — other than colds, flu, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy — had a 20% or more reduction in hours for 5 or more consecutive days due to a muscular injury or disorder of the neck, back, shoulder, knee, or other joint? | ☐ YES ☐ NO |
| 5 | In the last 2 years have you been treated for — or counseled for — alcohol or drug abuse? | ☐ YES ☐ NO |

**GROUP HOSPITAL INDEMNITY INSURANCE** ☐ New Coverage ☐ Change in Coverage

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

☒ Base Plan: ☒ Mid

☒Health Screening Benefit: ☒ yes

**Cost Per Pay Period Including any Riders:** _____

**If <u>NOT</u> Guaranteed Issue, answer the following questions**:

| | | **Applicant** | **Spouse** | **Children** |
|---|---|---|---|---|
| 1 | Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus? | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ 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. | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

| | | | | |
|---|---|---|---|---|
| 3 | Have you ever been treated for, or diagnosed with, any of the following:<br>a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder;<br>b) Kidney (renal) failure or end stage kidney (renal) disease;<br>c) Organ transplant;<br>d) Emphysema; or<br>e) High blood pressure, resulting in your now taking 3 or more medications for treatment? | ☐ **YES** ☐ **NO** | ☐ **YES** ☐ **NO** | ☐ **YES** ☐ **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? | ☐ **YES** ☐ **NO** | ☐ **YES** ☐ **NO** | ☐ **YES** ☐ **NO** |

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.

**HEALTH COVERAGES:**

- Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**
  **If yes, provide carrier:** _____
- 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 ☐ Cancer ☐ Accident ☐ Hospital Indemnity ☐ Disability

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.

Coverage will not become effective unless you are actively at work on the Certificate Effective Date. If you are not actively at work on that date, coverage will become effective on the date you return to an active work status.

CERTIFICATION: I certify that I have read the completed Employee Application /Statement of Insurability and the statements and answers that pertain to me and my spouse and my children. I certify that these statements and answers are true and complete to the best of my knowledge and belief, and that the statements and answers will be used by the insurance company to determine insurability. I realize any false statement or misrepresentation in the Employee Application /Statement of Insurability may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application /Statement of Insurability 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 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.

I certify that I am actively at work. I certify that my spouse is not currently disabled or unable to work. I certify that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

**Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.**

The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement of misrepresentation in the application may result in the loss of coverage under the policy.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____

Agent's Printed Name_____

Agent No._____ State of Enrollment_____

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