Aflac

Coverage is offered by:

CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

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		
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 **San Diego State University Research Foundation #21987**	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* Date of Birth	
Beneficiary Name/Relationship (estate unless designated otherwise)			

**Spouse* includes Domestic Partner as defined in California Family Code Section 297.	**Applicant**	**Spouse***
Are you actively at work?	☐ YES ☐ NO	
Is your spouse* now disabled or unable to 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

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

GROUP ACCIDENT INSURANCE ☐ New Coverage ☐ Change in Coverage

☒ Non-Occupational Plan: High

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

Cost per pay period: $_____

C01205CA

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse*

❑ New Coverage ❑ Change in Coverage

With Cancer: ☒ yes

☒ Heart Event Rider

Does the person to be insured have comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? ☐ YES ☐ NO

Persons without such comprehensive coverage are not eligible for coverage.

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
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: 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?	☐ YES ☐ NO	☐ YES ☐ NO

GROUP HOSPITAL INDEMNITY INSURANCE ☐ New Coverage ☐ Change in Coverage

Plan: 2

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

Does the person to be insured have comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? ☐ YES ☐ NO

Persons without such comprehensive coverage are not eligible for coverage.

Cost Per Pay Period Including any Riders: _____

If NOT Guaranteed Issue, answer the following questions:

		Applicant	Spouse*	Children
1	In the last 5 years, have you been treated for or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC)?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2	In the last 5 years, have you been treated for or diagnosed by a medical professional 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	In the last 5 years, have you been treated for, or diagnosed by a medical professional with, any of the following: a) Stroke, heart attack, heart disease, transient ischemia attacks (TIA); b) Disease or disorder of the endocrine system (diabetes, thyroid or other glands), liver; c) Kidney (renal) failure or end stage kidney (renal) disease; d) Organ transplant; e) Emphysema; or f) High blood pressure, resulting in your now taking 3 or more prescription medications for treatment?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

4	In the last 5 years, have you been treated by a medical professional or a professional counselor 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? **Illegal drugs refers to narcotics, controlled substances, and mind-altering substances that are not taken under supervision of a physician.	☐ **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.

- Does this coverage replace any existing Aflac individual policy? ☐ **YES** ☐ **NO**
  If **yes**, please identify which product: ☐ Critical Illness ☐ Accident ☐Hospital Indemnity ☐Dental ☐Disability
- 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 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 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 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 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 false statement or misrepresentation that was made in the Employee Application shall not bar the right to recovery under the Certificate unless such statement was made with intent to deceive Continental American Life Insurance Company or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.

To the best of my knowledge and belief, the answers to the questions on this enrollment form are true and complete.
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.