CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION

Please Mail: Post Office Box 427
Columbia, South Carolina 29202
800.433.3036

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

FOR AGENT USE ONLY				
☐ Initial Enrollment	☐ New Hire	☐ Re-Enrollment	☐ New 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
City and Borough of Juneau – Bartlett Group #20386			

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

	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
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

ACCIDENT

☑ Non-Occupational ☐ New Coverage ☐ Change in Coverage

☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family **Cost per pay period:** $__________

CRITICAL ILLNESS

☐ Employee ☐ Employee and Spouse ☐ New Coverage ☐ Change in Coverage

Employee Face Amount: $_____________ **Total cost per pay period:** $____________

Spouse Face Amount: $_____________ **Spouse cost per pay period:** $____________

		Employee	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.	☐ 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

DISABILITY INCOME

☐ 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 **19** 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**

	Elimination Period:	Accident: 0 days	Sickness: 7 days
Non-Occupational	**Benefit Period:**	3 months	
	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**
1	What is your current height and weight?	_____**ft** _____**in** _____**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**
	In the last 2 years have you been diagnosed, received medical advice, sought treatment (including surgery), or taken medication for 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; e) High blood pressure, resulting in your now taking 3 or more medications for treatment; **or** 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**
6	Have you, in the last 5 years: a) had your driver's license suspended or revoked, b) been charged with operating a motor vehicle while under the influence of drugs or alcohol, and/or c) been involved in 3 or more motor vehicle accidents?	☐ **YES** ☐ **NO**
7	In the past 5 years have you been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following: a) Systemic lupus or other connective tissue disease, fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, disc disease, or joint replacements; b) Multiple sclerosis, muscular dystrophy or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), or Huntington's disease; c) Schizophrenia, psychosis, major depressive disorder, bipolar disorder, or post-traumatic stress disorder; or d) Alzheimer's disease, dementia, organic brain disease, or memory loss?	☐ **YES** ☐ **NO**
8	In the past 2 years, have you had, or been treated for, or been told by a Doctor that you have: a) Neck, back, joint, bone, muscle, or tendon injury (excluding sprains or strains treated for less than 3 weeks or fractures not treated surgically); or b) Carpal Tunnel Syndrome?	☐ **YES** ☐ **NO**

This employee application is not complete unless signed and dated as indicated.

To the best of my knowledge and belief, the answers to the questions on this Employee 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
☐ 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 employed full-time on the enrollment date and on the effective date.

CERTIFICATION: I have read the completed Employee Application and I realize any false statement or misrepresentation in the Employee Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee 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.

I certify that I currently work full-time for the employer listed on this Employee Application and that my spouse is not currently disabled or unable to work.

A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.

Date____________ Signature of Applicant____

Date____________ Signature of Agent________________________Agent No.___________________ State of Enrollment_________

BI-WEEKLY RATES

AFLAC GROUP CRITICAL ILLNESS

- **Current certificateholders use the Buy Up rates when adding additional coverage. If you're interested in increasing your Critical Illness benefit amount, contact your benefits administrator.**

Employee / Bi-Weekly Rates								
AGES	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**
18-29	$2.08	$3.35	$4.62	$5.89	$7.16	$8.43	$9.69	$10.96
30-39	$2.98	$5.15	$7.32	$9.49	$11.66	$13.83	$15.99	$18.16
40-49	$5.36	$9.90	$14.45	$18.99	$23.54	$28.09	$32.63	$37.18
50-59	$9.21	$17.61	$26.01	$34.41	$42.81	$51.21	$59.61	$68.01
60-69	$16.46	$32.10	$47.75	$63.39	$79.04	$94.69	$110.33	$125.98
Employee and Spouse / Bi-Weekly Rates								
AGES	**$5k/$5k**	**$10k/$5k**	**$15k/$7.5k**	**$20k/$10k**	**$25k/$12.5k**	**$30k/$15k**	**$35k/$17.5k**	**$40k/$20k**
18-29	$4.16	$5.43	$7.33	$9.24	$11.14	$13.05	$14.94	$16.85
30-39	$5.96	$8.13	$11.38	$14.64	$17.89	$21.15	$24.39	$27.65
40-49	$10.72	$15.26	$22.08	$28.89	$35.72	$42.54	$49.35	$56.17
50-59	$18.42	$26.82	$39.42	$52.02	$64.62	$77.22	$89.82	$102.42
60-69	$32.92	$48.56	$72.03	$95.49	$118.97	$142.44	$165.90	$189.37

Employee / Bi-Weekly Buy Up Rates								
AGES	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**
18-29	$1.27	$2.54	$3.81	$5.08	$6.35	$7.62	$8.88	$10.15
30-39	$2.17	$4.34	$6.51	$8.68	$10.85	$13.02	$15.18	$17.35
40-49	$4.55	$9.09	$13.64	$18.18	$22.73	$27.28	$31.82	$36.37
50-59	$8.40	$16.80	$25.20	$33.60	$42.00	$50.40	$58.80	$67.20
60-69	$15.65	$31.29	$46.94	$62.58	$78.23	$93.88	$109.52	$125.17
Spouse / Bi-Weekly Buy Up Rates								
AGES	**$5k/$5k**	**$10k/$5k**	**$15k/$7.5k**	**$20k/$10k**	**$25k/$12.5k**	**$30k/$15k**	**$35k/$17.5k**	**$40k/$20k**
18-29	$2.54	$3.81	$5.71	$7.62	$9.52	$11.42	$13.33	$15.23
30-39	$4.34	$6.51	$9.76	$13.02	$16.27	$19.52	$22.78	$26.03
40-49	$9.09	$13.64	$20.46	$27.28	$34.10	$40.92	$47.73	$54.55
50-59	$16.80	$25.20	$37.80	$50.40	$63.00	$75.60	$88.20	$100.80
60-69	$31.29	$46.94	$70.41	$93.88	$117.35	$140.82	$164.28	$187.75

AFLAC GROUP ACCIDENT

Bi-Weekly Rates	
Coverage	**Premium**
Employee	$7.01
Employee & Spouse	$11.43
Employee & Child	$13.72
Family	$18.14

AFLAC GROUP DISABILITY

Age	Bi-Weekly Premium
18-49	$1.17
50-64	$1.25
65-74	$1.48