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		
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 **Virginia Lutheran Homes #22647**	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 ☐ New Coverage ☐ Change in Coverage

☒ 24 Hour Plan: High

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

☒ Sickness Rider

Cost per pay period: $_____

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage

With Cancer: ☒ yes Non-Invasive Cancer Benefit: ☒ yes Skin Cancer Benefit: ☒ yes

With Health Screening Benefit: ☒ yes Waiver of Premium: ☒ yes Building Benefit: ☒ yes ☒ Heart Event 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

C01205VA

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

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

Base Plan ☒ Low

Surgery Category – Inpatient and Outpatient ☒ Low

☒ Dependent Child Rider ☒ Dependent Spouse Rider

Cost Per Pay Period : _____

If NOT 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: 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	☐ 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 ☐ Dental ☐ 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, 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.