



**ENROLLMENT FORM**

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		
Hospital Indemnity		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)		S.S.N./ID Number	Gender	Date of Birth
Street Address		City	State	Zip
Employer		Job Class	Location	Date of Hire
Hours Worked	Daytime Phone No.	Beneficiary Name / Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth	
			Employee	Spouse
Are you actively at work?			<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now hospitalized or unable to perform your normal duties and activities?				<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

**Type of Coverage**

1	<b>CRITICAL ILLNESS</b>	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee & Spouse	Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employee Face Amount: \$ _____	Employee Cost per pay period: \$ _____	Spouse Face Amount: \$ _____	Spouse Cost per pay period: \$ _____
1a	Have you used tobacco products in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
1b	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
1c	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, Lymphoma, or 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	
1d	Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, b) any liver disorder in the last 5 years; c) kidney (renal) failure or end stage kidney (renal) disease in the last 5 years; d) organ transplant; e) emphysema in the last 10 years or f) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
2	<b>ACCIDENT</b>	<input checked="" type="checkbox"/> Non-Occupational	Plan: <u>High</u>	Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee & Children	<input type="checkbox"/> Family
				<b>Cost per pay period:</b> \$ _____

3	<b>HOSPITAL INDEMNITY</b> <input checked="" type="checkbox"/> Plan: <u>HSA 4</u>	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family	Cost per pay period: \$ _____	
<b>If NOT Guaranteed Issue, answer the following questions:</b>			
		<b>Employee</b>	<b>Spouse</b>
3a	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3b	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or 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
3c	Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the hear (including artery disease); diabetes, b) any liver disorder in the last 5 years; c) kidney (renal) failure or end stage kidney (renal) disease in the last 5 years; d) organ transplant; e) emphysema in the last 10 years or f) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3d	In the last 10 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
3e	Employee Height / Weight _____	Spouse Height / Weight _____	
<p>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.</p> <ul style="list-style-type: none"> <li>• Does this coverage replace or change any existing insurance?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</li> <li>• If "Yes," provide carrier and policy number: _____</li> </ul> <p>CERTIFICATION: I have read the completed application and 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 until my application is approved and the necessary premium is paid.</p> <p>Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.</p> <p>I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.</p> <p>I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pa period for my insurance. Deduction start date _____</p> <p><b>Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.</b></p> <p>Date _____ Signature of Applicant _____</p> <p>Date _____ Signature of Agent _____ Agent # _____ State of Enrollment <u>UT</u></p>			