CONTINENTAL AMERICAN INSURANCE COMPANY

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: Non CI Wrap

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**
Washington School District #12962			

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 Plan High Option ☐ New Coverage ☐ Change in Coverage

☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Cost per pay period: $_____

CRITICAL ILLNESS ☐ Employee ☐ Employee and Spouse With Cancer: ☒ Yes

☐ New Coverage ☐ Change in Coverage

Employee Face Amount: $_____ **Employee 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**

HOSPITAL INDEMNITY Plan: Custom_____

☐ New Coverage ☐ Change in Coverage

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

Notice to Buyer for Hospital Indemnity Coverage: This is a Hospital Confinement Indemnity certificate. This certificate provides limited benefits. Benefits are supplemental and are not intended to cover all medical expenses. Review your certificate carefully.

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

		Employee	Spouse	Children
1	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?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
2	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.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
3	Have you ever been treated for a) a stroke, a heart attack, a 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) now taking 3 or more medications for high blood pressure?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
4	Have you ever 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**

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

To the best of my knowledge and belief, the answers to the questions on this Enrollment Form are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

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 Enrollment Form and I realize any false statement or misrepresentation in the Enrollment Form may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Enrollment Form 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.

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.

The Certificate provides limited benefits. Review your certificate carefully.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____Agent No._____ State of Enrollment_____