



**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:				
<b>EFFECTIVE DATE:</b>				
FOR AGENT USE ONLY				
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> Newly Eligible	<input type="checkbox"/> 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 <b>Weld County #17611</b>		Job Class/Occupation	Location		Hire/Change of Status Date
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?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now disabled or unable to work?					<input type="checkbox"/> YES <input type="checkbox"/> NO
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

**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**    24 Hour   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:** \$ \_\_\_\_\_  
 Heart Event Rider  
**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)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**HOSPITAL INDEMNITY** Plan: 4

New Coverage  Change in Coverage

Employee  Employee & Spouse  Employee & Children  Family

Cost per pay period: \$ \_\_\_\_\_

If **NOT** 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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 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 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.

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.

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_ Signature of Agent \_\_\_\_\_ Agent No. \_\_\_\_\_ State of Enrollment \_\_\_\_\_