CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION
Please Mail: PO Box 84078,
Columbus, GA 31993
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Disability Income		
Endorsement:		
EFFECTIVE DATE: 01/01/2021		

FOR AGENT USE ONLY

☐ Initial Enrollment	☐ New Hire	☒ Re-Enrollment	☐ New Eligible	☐ Re-Submission

Deduction start date 01/15/2021

Applicant Name (First, MI, Last)		Social Security # or ID #		Gender	Date of Birth
Street Address	City			State	ZIP
Group Policyholder **Milwaukee Teachers Education Association #20722**	Class/Occupation	Location	Date of Hire		
E-mail address (optional)	Hours Worked per Week	Daytime Phone No.			
Spouse's Name (if coverage is requested)		Spouse's Gender	Spouse's Date of Birth		

	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

Beneficiary Information – Employee's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

Beneficiary Information – Spouse's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

GROUP ACCIDENT INSURANCE

☐ New Coverage ☐ Change in Coverage ☐Increase/Buy-Up

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

Cost per pay period: $_____

GROUP DISABILITY INCOME INSURANCE ☐New Coverage ☐Change in Coverage ☐Increase/Buy-Up ☐Term Life Rider

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?			☐YES ☐NO
Do you earn at least $9,000 base annual pay working for your Employer, the Policyholder?			☐YES ☐NO
	Elimination Period:	Accident: 14	Sickness: 14
Annual Salary: $	**Benefit Period:**	6-month	
Monthly Benefit Amount: $	**Cost per pay period:**	$	
If you are a resident of California, Hawaii, New Jersey, New York, or Rhode Island, are you covered by your state's Temporary Disability Insurance (TDI) or an equivalent state disability insurance plan? (If you are not a resident of any of these states, please mark no).			☐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
3	In the last 2 years have you been diagnosed with, 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 with, 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

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.

ALL COVERAGES:
If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify the company.

To the best of my knowledge and belief, my answers to the questions are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. 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 unless I am actively at work on the effective date of coverage, and until my application is approved and the necessary premium is paid. If I am not actively at work on the effective date of coverage, coverage will become effective on the date I return to an active work status.

I understand and agree that the coverage I am applying for may have a pre-existing condition limitation.

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 that I am actively at work. If applicable, I certify to the best of my knowledge and belief that my spouse is not currently disabled or unable to work. If applicable, I certify to the best of my knowledge and belief that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.

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's Printed Name Kara Stadel

Agent No. YU823 State of Enrollment WI

Agent's certification: To the best of my knowledge, I certify this policy will not replace or change any existing life insurance policy(ies). I have provided the applicant with the required accelerated benefit disclosures.

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