

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Critical Illness Enrollment Form/

Filing at a Glance

Company: Continental American Insurance Company
Product Name: Critical Illness
State: Arkansas
TOI: H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI: H07G.001 Critical Illness
Filing Type: Form
Date Submitted: 11/01/2012
SERFF Tr Num: CAIC-128752559
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 9085
Implementation: On Approval
Date Requested:
Author(s): Sara McCormick
Reviewer(s): Donna Lambert (primary)
Disposition Date: 11/05/2012
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Critical Illness
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General Information

Project Name: Critical Illness Enrollment Form Status of Filing in Domicile: Pending
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Employer, Other Explanation for Other Group Market Type: Union
 Overall Rate Impact: Filing Status Changed: 11/05/2012
 State Status Changed: 11/05/2012
 Deemer Date: Created By: Sara McCormick
 Submitted By: Sara McCormick Corresponding Filing Tracking Number:

Filing Description:

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130
 TOI: H07G Group Health - Specified Disease - Limited Benefit
 Sub-TOI: H07G.001 Critical Illness
 Proposed Effective Date: On Approval
 Domicile State Approval: SC – Pending
 Form: C20207.1 – Enrollment Form

Dear Sir or Madam:

The above-captioned form is being filed for your review and approval. This is a new filing and will not replace any other forms on file with your department.

The enrollment form will be used with group critical illness forms approved by your department.

If you have any questions or require additional information, please contact Sara McCormick either at 1.888.730.2244, ext. 4952 or at companycompliance@aflac.com. Thank you for your consideration in this matter.

Company and Contact

Filing Contact Information

Sara McCormick, Regulatory Analyst smccormick@caicworksite.com
 2801 Devine Street 803-354-4952 [Phone]
 Columbia, SC 29205

Filing Company Information

Continental American Insurance Company	CoCode: 71730	State of Domicile: South Carolina
2801 Devine Street	Group Code:	Company Type: LAH
Columbia, SC 29205	Group Name: Continental Amer Ins Co	State ID Number:
(803) 256-6265 ext. [Phone]	FEIN Number: 57-0514130	

Filing Fees

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
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Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: South Carolina's domiciliary fee is \$0; therefore, we are submitting the Arkansas fee of \$50.00/application form.
 Per Company: No

Company	Amount	Date Processed	Transaction #
Continental American Insurance Company	\$50.00	11/01/2012	64473355

SERFF Tracking #:

CAIC-128752559

State Tracking #:

Company Tracking #:

9085

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

Critical Illness

Project Name/Number:

Critical Illness Enrollment Form/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	11/05/2012	11/05/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	11/01/2012	11/01/2012

Response Letters

Responded By	Created On	Date Submitted
Sara McCormick	11/02/2012	11/02/2012

SERFF Tracking #:

CAIC-128752559

State Tracking #:

Company Tracking #:

9085

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

Critical Illness

Project Name/Number:

Critical Illness Enrollment Form/

Disposition

Disposition Date: 11/05/2012

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Variability Statement	Approved	Yes
Form (revised)	Enrollment Form	Approved	Yes
Form	Enrollment Form	Replaced	Yes

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Critical Illness Enrollment Form/

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/01/2012
Submitted Date	11/01/2012
Respond By Date	12/03/2012

Dear Sara McCormick,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Enrollment Form, C20207.1 (Form)

Comments: Please use the fraud statement provided in ACA 23-66-503: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking #:

CAIC-128752559

State Tracking #:

Company Tracking #:

9085

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

Critical Illness

Project Name/Number:

Critical Illness Enrollment Form/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/02/2012
Submitted Date	11/02/2012

Dear Donna Lambert,

Introduction:

Please see my response to your objection below.

Response 1

Comments:

I have revised the fraud statement to reflect what is provided in ACA 23-66-503.

Related Objection 1

Applies To:

- Enrollment Form, C20207.1 (Form)

Comments: Please use the fraud statement provided in ACA 23-66-503: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name: Critical Illness

Project Name/Number: Critical Illness Enrollment Form/

Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Enrollment Form	C20207.1AR	AEF	Initial		0.000	C20207.1AR Revised Critical Illness Enrollment Form 10302012.pdf	Date Submitted: 11/02/2012 By: Sara McCormick
<i>Previous Version</i>								
1	<i>Enrollment Form</i>	<i>C20207.1</i>	<i>AEF</i>	<i>Initial</i>		<i>0.000</i>	<i>C20207.1 Critical Illness Enrollment Form.pdf</i>	<i>Date Submitted: 11/01/2012 By: Sara McCormick</i>

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this filing.

Sincerely,

Sara McCormick

Sincerely,

Sara McCormick

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: Critical Illness Enrollment Form/

Form Schedule

Lead Form Number: C20207.1

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 11/05/2012	Enrollment Form	C20207.1A R	AEF	Initial		0.000	C20207.1AR Revised Critical Illness Enrollment Form 10302012.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



**CONTINENTAL AMERICAN
INSURANCE COMPANY**

ENROLLMENT FORM

Please Mail To: [Post Office Box 427
Columbia, South Carolina 29202
800.433.3036]

FOR HOME OFFICE USE ONLY				
PLAN	PLAN CODE	ID NUMBER		
<i>Critical Illness</i>				
Endorsement:				
EFFECTIVE DATE:				
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/Certificate Holder (First, MI, Last)		Social Security Number/ID Number	Gender	Date of Birth
Street Address		City	State	ZIP
[Employer]		Job Class/Occupation	Location	Hire Date/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 [part-time;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

CRITICAL ILLNESS [Employee] [Employee] and Spouse] [Section 125: Yes No] [With Cancer: Yes No]

New Coverage] Change in Coverage]

[Employee] Face Amount: \$ _____ [Employee] cost per pay period: \$ _____

Automatic Increase Rider] Dependent Child Benefit Rider] Heart Event Rider]

Specified Critical Illness Rider] Genetic Screening Test Rider]

Spouse Face Amount: \$ _____ Spouse cost per pay period: \$ _____

[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [\$x.xx].]

		[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
[4]	Have you ever received any advice, treatment, or consultation for: any disorder of the central nervous system, Parkinson's Disease, Alzheimer's Disease, dementia, senility, or organic brain syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[[5]	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[All applicants enrolling in coverage over [\$50,000] in Employee benefits MUST answer the following additional questions:			
[[6]	Height/Weight	ft in lbs	ft in lbs]

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

[[7]	Have you been advised to have any diagnostic test, hospitalization, surgery, or treatment that has not yet been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO]
[[8]	In the past two years, have you had a systolic blood pressure reading of 150 or above or a diastolic blood pressure reading of 100 or above?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO]
[[9]	Have you had an annual physical examination in the last [6 months]? If yes, provide name and address of physician and date of exam. _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO]]

[Does this coverage replace any existing Aflac individual policy?
Does this coverage replace or change any existing insurance?

YES NO
 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 [part-time; 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.]

[I certify that I currently work [part-time; full-time] for the [employer] listed on this enrollment form [and that my spouse is not currently disabled or unable to work]. [I further certify that neither my spouse nor I have used tobacco products in the last 12 months.]]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ Agent No. _____ State of Enrollment _____



Things to Consider Before Replacing Your Existing Insurance Coverage

Aflac’s goal is to provide you with outstanding insurance products that offer important financial protection to you and your loved ones in the event of an accident or illness. To best serve our customers, we offer a robust portfolio of products designed to respond to a variety of needs and circumstances. If you are thinking about replacing one type of policy for another, please be aware that there are important differences between insurance products—specifically group products versus individual products. These differences may affect your coverage. Before making a change to any existing coverage you may have, please make sure to carefully compare the benefits provided by your existing policy and the proposed replacement coverage. Among the items you should consider are the following:

1. If you are currently receiving treatment for an injury or illness: Your new coverage will not cover claims for treatment received as a result of injuries or illnesses diagnosed prior to its effective date.
2. If you terminate existing coverage, no benefits will be paid for diagnoses or treatments you receive after the termination date.
3. Benefits of your existing policy and the replacement coverage you’re considering may be different, and you may be subject to new waiting periods and/or coverage exclusions due to preexisting conditions.
4. If you terminate an existing policy, you will lose any accrued benefits. Any such accrued benefits cannot be transferred to new coverage.
5. Individual insurance coverage is guaranteed-renewable and cannot be cancelled for any reason other than non-payment of premium.
6. Group insurance coverage is not guaranteed-renewable. If the master policy held by your employer or organization is cancelled, your coverage terminates.
7. Individual insurance coverage is fully portable. If you leave your current job, you can retain your individual insurance coverage.
8. Group coverage has limited portability. If you change jobs, you may not be able to retain your coverage.

By signing below, I acknowledge that I have received this notice and wish to apply for new coverage.

Signature of Applicant _____ Date _____

Applicant’s Name (printed) _____

Address (printed) _____

E-Mail Address _____ Telephone _____]

SERFF Tracking #:

CAIC-128752559

State Tracking #:**Company Tracking #:**

9085

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

Critical Illness

Project Name/Number:

Critical Illness Enrollment Form/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	11/05/2012
Comments:	These application forms are intended to be used with our group critical illness forms approved by your department with a Flesch Reading Score which exceeded the minimum requirement of 40.		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	11/05/2012
Comments:	This filing is solely for an application form.		

		Item Status:	Status Date:
Satisfied - Item:	Variability Statement	Approved	11/05/2012
Comments:			
Attachment(s):			
C20408 CI Enrollment Form Variability Statement.pdf			

CONTINENTAL AMERICAN INSURANCE COMPANY

VARIABILITY STATEMENT: GROUP CRITICAL ILLNESS ENROLLMENT FORM

ENROLLMENT FORM (C20207.1)

Variable information is bracketed <i>throughout the form</i> * as follows:	
Throughout the documents, [Employee] is bracketed.	[Employee/Member] applies to each occurrence.
Throughout the documents, [full; part] is bracketed.	[full/part] will indicate whether the group's employees are full- or part-time.
*Please note: Bracketed items listed above are NOT highlighted or explained elsewhere in this variability statement.	
Additional bracketed items outlined <i>individually</i> :	
	The Aflac logo is variable so that necessary changes to the logo can be incorporated.
[Post Office Box 427 Columbia, South Carolina 29202 800.433.3036]	The address is variable so necessary changes can be incorporated.
[Employer]	This will reflect the type of group – can be replaced with terms employer, policyholder, association, union
[Are you currently working [part-time;full-time] for the [employer] listed above?] [Are you now disabled or unable to work?] [Have you used tobacco products in the last 12 months?]	Eligibility Questions: will be either included or deleted from the form based on negotiations with the prospective policyholder and his needs.
CRITICAL ILLNESS <input type="checkbox"/> [Employee] <input type="checkbox"/> [Employee] and Spouse <input type="checkbox"/> Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> With Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage [Employee] Face Amount: \$ _____ [Employee] cost per pay period: \$ ____ <input type="checkbox"/> Automatic Increase Rider <input type="checkbox"/> Dependent Child Benefit Rider <input type="checkbox"/> Heart Event Rider <input type="checkbox"/> Specified Critical Illness Rider <input type="checkbox"/> Genetic Screening Test Rider	Types of coverage can be removed if all types are not offered to a group. Optional riders - either included or deleted from the forms based on negotiations with the prospective policyholder and his needs.
[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [\$x.xx].]	
<div style="float: right; text-align: right;"> Provision can be removed depending on account administration. Frequency can be changed depending on account administration. The correct fee for the individual certificate </div>	

	holder will be included.
<ol style="list-style-type: none"> 1. [Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? 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. 3. Have you ever been treated for, or diagnosed with, any of the following: <ol style="list-style-type: none"> a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery b) disease), diabetes, or any liver disorder; c) Kidney (renal) failure or end stage kidney (renal) disease; d) Organ transplant; e) Emphysema; or f) high blood pressure, resulting in your now taking 3 or more medications for treatment? 4. [Have you ever received any advice, treatment, or consultation for: any disorder of the central nervous system, Parkinson’s Disease, Alzheimer’s Disease, dementia, senility, or organic brain syndrome?] 5. [In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?] <p>[All applicants enrolling in coverage over [\$50,000] in Employee benefits MUST answer the following additional questions:</p> <ol style="list-style-type: none"> 6. [Height/Weight ft in lbs ft in lbs] 7. [Have you been advised to have any diagnostic test, hospitalization, surgery, or treatment that has not yet been completed?] 8. [In the past two years, have you had a systolic blood pressure reading of 150 or above or a diastolic blood pressure reading of 100 or above?] 9. [Have you had an annual physical examination in the last [6 months]? If yes, provide name and address of physician and date of exam.] 	<p>[Questions are bracketed so they can be removed according to the coverage the group has chosen.]</p>
<p>[Does this coverage replace any existing Aflac individual policy? <input type="checkbox"/> YES <input type="checkbox"/> NO]</p>	<p>[Statement will either be included or deleted based on the needs of the prospective policyholder.]</p>
<p>[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.]</p>	<p>[Statement will be either included or deleted from the enrollment form based on the needs of the prospective policyholder.]</p>
<p>[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.]</p>	<p>[Can be adjusted to reflect a different payment method if applicable.] [Policyholder]</p>
<p>[I certify that I currently work [part-time; full-time] for the [employer] listed on this enrollment form [and that my spouse is not currently disabled or unable to work]. [I further certify that neither my spouse nor I have used tobacco products in the last 12 months.]</p>	<p>[Either included or deleted from the enrollment form based on the needs of the prospective policyholder.]</p>
<p>[Things to Consider Before Replacing Your Existing Insurance Coverage]</p>	<p>[The Disclosure page titled “Things to Consider Before Replacing Your Existing Insurance Coverage”, will be either included or deleted from the enrollment form based on the needs of the prospective policyholder.]</p>

SERFF Tracking #:

CAIC-128752559

State Tracking #:**Company Tracking #:**

9085

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

Critical Illness

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Critical Illness Enrollment Form/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/01/2012	Replaced 11/05/2012	Form	Enrollment Form	11/02/2012	C20207.1 Critical Illness Enrollment Form.pdf (Superceded)



**CONTINENTAL AMERICAN
INSURANCE COMPANY**

ENROLLMENT FORM

Please Mail To: [Post Office Box 427
Columbia, South Carolina 29202
800.433.3036]

FOR HOME OFFICE USE ONLY				
PLAN	PLAN CODE	ID NUMBER		
<i>Critical Illness</i>				
Endorsement:				
EFFECTIVE DATE:				
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/Certificate Holder (First, MI, Last)		Social Security Number/ID Number	Gender	Date of Birth
Street Address		City	State	ZIP
[Employer]		Job Class/Occupation	Location	Hire Date/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 [part-time;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

CRITICAL ILLNESS [Employee] [Employee] and Spouse] [Section 125: Yes No] [With Cancer: Yes No]

New Coverage] Change in Coverage]

[Employee] Face Amount: \$ _____ [Employee] cost per pay period: \$ _____

Automatic Increase Rider] Dependent Child Benefit Rider] Heart Event Rider]

Specified Critical Illness Rider] Genetic Screening Test Rider]

Spouse Face Amount: \$ _____ Spouse cost per pay period: \$ _____

[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [\$x.xx].]

		[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
[4]	Have you ever received any advice, treatment, or consultation for: any disorder of the central nervous system, Parkinson's Disease, Alzheimer's Disease, dementia, senility, or organic brain syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[[5]	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
[All applicants enrolling in coverage over [\$50,000] in Employee benefits MUST answer the following additional questions:			
[[6]	Height/Weight	ft in lbs	ft in lbs]

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

[[7]	Have you been advised to have any diagnostic test, hospitalization, surgery, or treatment that has not yet been completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO]]
[[8]	In the past two years, have you had a systolic blood pressure reading of 150 or above or a diastolic blood pressure reading of 100 or above?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO]]
[[9]	Have you had an annual physical examination in the last [6 months]? If yes, provide name and address of physician and date of exam. _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO]]

[Does this coverage replace any existing Aflac individual policy?
Does this coverage replace or change any existing insurance?

YES NO
 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 [part-time; 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.]

[I certify that I currently work [part-time; full-time] for the [employer] listed on this enrollment form [and that my spouse is not currently disabled or unable to work]. [I further certify that neither my spouse nor I have used 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 No. _____ State of Enrollment _____



Things to Consider Before Replacing Your Existing Insurance Coverage

Aflac's goal is to provide you with outstanding insurance products that offer important financial protection to you and your loved ones in the event of an accident or illness. To best serve our customers, we offer a robust portfolio of products designed to respond to a variety of needs and circumstances. If you are thinking about replacing one type of policy for another, please be aware that there are important differences between insurance products—specifically group products versus individual products. These differences may affect your coverage. Before making a change to any existing coverage you may have, please make sure to carefully compare the benefits provided by your existing policy and the proposed replacement coverage. Among the items you should consider are the following:

1. If you are currently receiving treatment for an injury or illness: Your new coverage will not cover claims for treatment received as a result of injuries or illnesses diagnosed prior to its effective date.
2. If you terminate existing coverage, no benefits will be paid for diagnoses or treatments you receive after the termination date.
3. Benefits of your existing policy and the replacement coverage you're considering may be different, and you may be subject to new waiting periods and/or coverage exclusions due to preexisting conditions.
4. If you terminate an existing policy, you will lose any accrued benefits. Any such accrued benefits cannot be transferred to new coverage.
5. Individual insurance coverage is guaranteed-renewable and cannot be cancelled for any reason other than non-payment of premium.
6. Group insurance coverage is not guaranteed-renewable. If the master policy held by your employer or organization is cancelled, your coverage terminates.
7. Individual insurance coverage is fully portable. If you leave your current job, you can retain your individual insurance coverage.
8. Group coverage has limited portability. If you change jobs, you may not be able to retain your coverage.

By signing below, I acknowledge that I have received this notice and wish to apply for new coverage.

Signature of Applicant _____ Date _____

Applicant's Name (printed) _____

Address (printed) _____

E-Mail Address _____ Telephone _____]