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**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** /

## Filing at a Glance

Company: Continental American Insurance Company  
Product Name: Combo Applications  
State: Arkansas  
TOI: H21 Health - Other  
Sub-TOI: H21.000 Health - Other  
Filing Type: Form  
Date Submitted: 11/21/2012  
SERFF Tr Num: CAIC-128778180  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 9211  
  
Implementation: On Approval  
Date Requested:  
Author(s): Sara McCormick  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 11/21/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** /

**Filing Company:** Continental American Insurance Company

## General Information

Project Name: 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: 11/21/2012  
State Status Changed: 11/21/2012  
Deemer Date: Created By: Sara McCormick  
Submitted By: Sara McCormick Corresponding Filing Tracking Number:  
PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

### Filing Description:

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130  
TOI: H21 — Other  
Sub-TOI: H21.000 Health — Other  
Proposed Effective Date: On Approval  
Domicile State Approval: SC – Pending  
Forms: C00205.1AR Combo 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. This form will be used with group health forms approved by your department.

We would like to be able to customize this form as needed for each group and ask that you consider each section (Accident, Critical Illness, Hospital Indemnity, Dental, and Disability Income) as variable. This will enable us to delete that specific product section when the product(s) are not being sold to a particular group. Example – If the employer was interested in offering only accident and critical illness insurance to his employees, the form would only contain those two sections.

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](mailto:companycompliance@aflac.com). Thank you for your consideration in this matter.

Sincerely,

James J. Hennessy, AIRC, CCP  
2nd Vice President, Compliance  
/scm

## Company and Contact

**State:** Arkansas **Filing Company:** Continental American Insurance Company  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** /

**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	State ID Number:
(803) 256-6265 ext. [Phone]	Ins Co	
	FEIN Number: 57-0514130	

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: Since South Carolina's domiciliary fee is \$0, we are submitting Arkansas's fee of \$50 per form \* 1 form = \$50.00.  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Continental American Insurance Company	\$50.00	11/21/2012	65109098

SERFF Tracking #:

CAIC-128778180

State Tracking #:

Company Tracking #:

9211

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Combo Applications

Project Name/Number:

/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/21/2012	11/21/2012

SERFF Tracking #:

CAIC-128778180

State Tracking #:

Company Tracking #:

9211

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Combo Applications

Project Name/Number:

/

## Disposition

Disposition Date: 11/21/2012

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Variability Statement	Approved-Closed	Yes
Form	Combo Enrollment Form	Approved-Closed	Yes

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Combo Applications  
**Project Name/Number:** /

**Filing Company:** Continental American Insurance Company

## Form Schedule

Lead Form Number: C00205.1AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/21/2012	Combo Enrollment Form	C00205.1AR	AEF	Initial		0.000	C00205.1AR Combo Enrollment Form.pdf

### Form Type Legend:

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



**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]		
[Dental]		
[Disability Income]		
[Hospital Indemnity]		
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"/> New 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]	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 [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	

**[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  Non-Occupational] Plan \_\_\_\_\_  New Coverage]  Change in Coverage]  
 [Employee]  [Employee] & Spouse]  [Employee] & Children]  Family] [Section 125:  Yes  No]  
 Sickness Rider]  Dependent Rider]  Catastrophic Rider]  Total Disability Rider]  Gunshot Wound Rider]  
**Cost per pay period:[Including any Riders]\$\_\_\_\_\_**  
**[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]**

**[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 \$[0.58].]**

		[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
[[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

**[DENTAL]**     [Employee]     [Employee] & Spouse     [Employee] & Children     Family    [Section 125:  Yes  No]

New Coverage     Change in Coverage

Level 1 Plan \$25 Dental Wellness     Level 2 Plan \$50 Dental Wellness     Level 3 Plan \$50 Dental Wellness

Orthodontic Benefit Rider]  Cosmetic Benefit Rider - Not available with 125 Plans]

**Cost Per Pay Period [Including any Riders]** \_\_\_\_\_

**[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]**

[1]	I understand that the dental plan I am applying for will not cover any person who has attained age 71 before the Effective Date of my certificate.	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	I understand that the dental plan I am applying for contains different Waiting Periods for benefits listed in the Schedule of Dental Procedures. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the Effective Date of my certificate.	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.	<input type="checkbox"/> YES <input type="checkbox"/> NO

**[DISABILITY INCOME]**     24 Hour]  Non-Occupational]    Class:  [Premier]     [Select]]     [Choice]]  
Annual Salary \$ \_\_\_\_\_    [Section 125:  Yes  No]

New Coverage]     Change in Coverage]

Riders: \_\_\_\_\_ Monthly Benefit Amount: \$ \_\_\_\_\_    **Cost per pay period: \$** \_\_\_\_\_

Elimination Period: Accident: \_\_\_\_\_ [Sickness: \_\_\_\_\_] Benefit Period: \_\_\_\_\_

**[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]**

**[If NOT Guaranteed Issue, answer the following questions:]**

[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
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
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
4	In the last twelve (12) months, have you missed more than five (5) consecutive days of work due to illness or injury other than pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	Are you taking prescription medications on a regular basis for any back, neck, knee, or shoulder condition, rheumatoid or degenerative arthritis, respiratory disease, urinary or digestive disease, immune system disease or disorder, mental or nervous disorder? (This does not include simple infections/viral infections treated short term with antibiotics)	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	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]

**[HOSPITAL INDEMNITY]** Plan: \_\_\_\_\_ [Section 125:  Yes  No]  
 New Coverage]  Change in Coverage]  
 [Employee]  [Employee] & Spouse]  [Employee] & Children]  Family] **Cost per pay period:** \$ \_\_\_\_\_

**[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]**

**[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]]

**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 any existing Aflac individual policy?  YES  NO

If Yes, please identify which product:

Critical Illness]

Accident]

Hospital Indemnity]

Dental]

Disability]]

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 [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].]

**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-128778180

State Tracking #:

Company Tracking #:

9211

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Combo Applications

Project Name/Number:

/

## Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	11/21/2012
Bypass Reason:	This application form will be used with forms previously approved by your department with a Flesch score which meets or exceeds your minimum requirement.		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/21/2012
Bypass Reason:	This is an application-only filing.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/21/2012
Bypass Reason:	This is an application-only filing and does not affect rates in any way.		

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/21/2012
Bypass Reason:	Not an Individual Health Product.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/21/2012
Bypass Reason:	Not PPACA-related.		

		Item Status:	Status Date:
Satisfied - Item:	Variability Statement	Approved-Closed	11/21/2012
Comments:			
Attachment(s):			
C00400 Variability Statement.pdf			

# CONTINENTAL AMERICAN INSURANCE COMPANY

## VARIABILITY STATEMENT

### ENROLLMENT FORM (C00205.1AR)

Variable information is bracketed <i>throughout the forms</i> * as follows:	
Throughout the documents, <b>[Employee]</b> is bracketed.	<b>[Employee/Member]</b> applies to each occurrence.
Throughout the documents, <b>[Employees]</b> is bracketed.	<b>[Employees/Members]</b> applies to each occurrence.
Throughout the documents, <b>[Employees']</b> is bracketed.	<b>[Employees'/Members']</b> applies to each occurrence.
Throughout the documents, <b>[full]</b> is bracketed.	<b>[full/part]</b> will indicate whether the group's employees are full- or part-time. It will be available based negotiations with the prospective policyholder and his needs.
<b>*Please note: Bracketed items listed above are NOT highlighted or explained elsewhere in this variability statement.</b>	
	<b>[The Aflac logo is variable so that necessary changes to the logo can be incorporated.]</b>
<b>[2801 Devine Street, Columbia, South Carolina 29205 800.433.3036]</b>	<b>[The address is variable so necessary changes can be incorporated.]</b>
<b>[Employer]</b>	<b>[This will reflect the type of group – can be replaced with terms employer, policyholder, association, union]</b>
<b>[Are you currently working [part-time;full-time] for the [employer] listed above?]</b> <b>[Are you now disabled or unable to work?]</b> <b>[Have you used tobacco products in the last 12 months?]</b>	<b>[Questions will be included or deleted based on the plans chosen and negotiations with the prospective policyholder.]</b> <b>[Full- or part-time will be included based on negotiations with the prospective policyholder.]</b>

<b>[ACCIDENT</b> <input type="checkbox"/> 24 Hour] <input type="checkbox"/> Non-Occupational] Plan _____ <input type="checkbox"/> New Coverage] <input type="checkbox"/> Change in Coverage] <input type="checkbox"/> [Employee] <input type="checkbox"/> [Employee] & Spouse] <input type="checkbox"/> [Employee] & Children] <input type="checkbox"/> Family] [Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No] <input type="checkbox"/> [Sickness Rider] <input type="checkbox"/> [Dependent Rider] <input type="checkbox"/> [Catastrophic Rider] <input type="checkbox"/> [Total Disability Rider] <input type="checkbox"/> [Gunshot Wound Rider] Cost per pay period:[Including any Riders]\$_____	<b>[Product will be included or deleted based on negotiations with the prospective policyholder.]</b> <b>[Section 125, New or Change in Coverage: will be either included or deleted from the form]</b>
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<p>[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]</p>	<p>based on negotiations with the prospective policyholder and his needs.  Type of coverage and specific riders will be included or deleted based on negotiations with the prospective policyholder.  Provision can be removed depending on account administration.  [Frequency can be changed depending on account administration.]  [The correct fee for the individual certificate holder will be included.]</p>
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<p><b>CRITICAL ILLNESS</b> <input type="checkbox"/> [Employee] <input type="checkbox"/> [Employee] and Spouse ] [Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No] [With Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No]</p> <p><input type="checkbox"/> New Coverage] <input type="checkbox"/> Change in Coverage]</p> <p>[Employee] Face Amount: \$_____ [Employee] cost per pay period: \$____</p> <p><input type="checkbox"/> Automatic Increase Rider] <input type="checkbox"/> Dependent Child Benefit Rider] <input type="checkbox"/> Heart Event Rider]</p> <p><input type="checkbox"/> Specified Critical Illness Rider] <input type="checkbox"/> Genetic Screening Test Rider]</p> <p>[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [\$x.xx].]</p>	<p>Product will be included or deleted based on negotiations with the prospective policyholder.  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.  Provision can be removed depending on account administration.  Frequency can be changed depending on account administration.  The correct fee for the individual certificate holder will be included.</p>
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<ol style="list-style-type: none"> <li>1. Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?</li> <li>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.</li> <li>3. Have you ever been treated for, or diagnosed with, any of the following: <ol style="list-style-type: none"> <li>a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—</li> </ol> </li> </ol>	<p>Questions are bracketed so they can be removed according to the coverage the group has chosen.</p>
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<p>including artery</p> <p>b) disease), diabetes, or any liver disorder;</p> <p>c) Kidney (renal) failure or end stage kidney (renal) disease;</p> <p>d) Organ transplant;</p> <p>e) Emphysema; or</p> <p>f) high blood pressure, resulting in your now taking 3 or more medications for treatment?</p> <p>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?]</p> <p>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> <p>[All applicants enrolling in coverage over [\$50,000] in Employee benefits MUST answer the following additional questions:</p> <p>6. [Height/Weight ft in lbs ft in lbs]</p> <p>7. [Have you been advised to have any diagnostic test, hospitalization, surgery, or treatment that has not yet been completed?]</p> <p>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?]</p> <p>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>	
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<p><b>DENTAL</b>      <input type="checkbox"/> [Employee]   <input type="checkbox"/> [Employee] &amp; Spouse   <input type="checkbox"/> [Employee] &amp; Children   <input type="checkbox"/> Family]</p> <p>[Section 125: <input type="checkbox"/> Yes   <input type="checkbox"/> No]</p> <p><input type="checkbox"/> New Coverage]      <input type="checkbox"/> Change in Coverage]</p> <p><input type="checkbox"/> Level 1 Plan \$25 Dental Wellness]      <input type="checkbox"/> Level 2 Plan \$50 Dental Wellness]      <input type="checkbox"/> Level 3 Plan \$50 Dental Wellness]</p> <p><input type="checkbox"/> Orthodontic Benefit Rider] <input type="checkbox"/> Cosmetic Benefit Rider - Not available with 125 Plans]</p> <p><b>Cost Per Pay Period [Including any Riders]</b> _____</p> <p><b>[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]</b></p>	<p>Product will be included or deleted based on negotiations with the prospective policyholder.</p> <p>Types of coverage can be removed if all types are not offered to a group.</p> <p>Section 125, New or Change in Coverage: will be either included or deleted from the form based on negotiations with the prospective policyholder and his needs.</p> <p>Plan level and specific riders will be chosen based on negotiations with prospective policyholder and his needs.</p> <p>Provision can be removed depending on account administration.</p> <p>Frequency can be changed depending on account administration.</p> <p>The correct fee for the individual certificate holder will be included.</p>
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<p><b>DISABILITY INCOME</b>      <input type="checkbox"/> 24 Hour]   <input type="checkbox"/> Non-Occupational]   Class:   <input type="checkbox"/> Premier]</p> <p><input type="checkbox"/> [Select]]   <input type="checkbox"/> [Choice]]</p>	<p>Product will be included or deleted based on</p>
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Annual Salary \$ \_\_\_\_\_  
 [Section 125:  Yes  No]  
 New Coverage  Change in Coverage  
 Riders: \_\_\_\_\_ Monthly Benefit Amount: \$ \_\_\_\_\_ Cost per  
 pay period: \$ \_\_\_\_\_  
 Elimination Period: Accident: \_\_\_\_\_ [Sickness: \_\_\_\_\_ ] Benefit Period: \_\_\_\_\_

[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]

**If NOT Guaranteed Issue, answer the following questions:**

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

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

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

In the last twelve (12) months, have you missed more than five (5) consecutive days of work due to illness or injury other than pregnancy?  YES  NO

Are you taking prescription medications on a regular basis for any back, neck, knee, or shoulder condition, rheumatoid or degenerative arthritis, respiratory disease, urinary or digestive disease, immune system disease or disorder, mental or nervous disorder? (This does not include simple infections/viral infections treated short term with antibiotics)  YES  NO

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

negotiations with the prospective policyholder.  
 Types of coverage can be removed if all types are not offered to a group.  
 Section 125, New or Change in Coverage: will be either included or deleted from the form based on negotiations with the prospective policyholder and his needs.

Provision can be removed depending on account administration.  
 Frequency can be changed depending on account administration.  
 The correct fee for the individual certificate holder will be included.

Questions are bracketed so they can be removed according to the coverage the group has chosen.

**HOSPITAL INDEMNITY** [Section 125:  Yes  No]

New Coverage  Change in Coverage

[Employee]  [Employee] & Spouse  [Employee] & Spouse ]  [Family ]

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

Product will be included or deleted based on negotiations with the prospective policyholder.  
 Section 125, New or Change in Coverage: will be either included or deleted from the form based on negotiations with the prospective policyholder and his needs.  
 Types of coverage can

	<p>be removed if all types are not offered to a group.</p> <p>Provision can be removed depending on account administration.  Frequency can be changed depending on account administration.  The correct fee for the individual certificate holder will be included.</p>
<ol style="list-style-type: none"> <li>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?]</li> <li>[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.]</li> <li>[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?]</li> <li>[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?]</li> </ol>	<p>Questions are bracketed so they can be removed according to the coverage the group has chosen. Questions will be removed for guaranteed issue situations.</p>

<p>Does this coverage replace any existing Aflac individual policy? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If Yes, please identify which product:</p> <p><input type="checkbox"/> Critical Illness]</p> <p><input type="checkbox"/> Accident]</p> <p><input type="checkbox"/> Hospital Indemnity]</p> <p><input type="checkbox"/> Dental]</p> <p><input type="checkbox"/> Disability]</p>	<p>The entire question may be included or deleted based on the needs of the prospective policyholder. Products may be included or deleted based on what is being offered.</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>Coverage will not become effective unless you are employed [part-time; full-time] on the enrollment date and on the effective date.</p>	<p>Full- or part-time is chosen based on the needs of the prospective policyholder.</p>
<p>I certify that I currently work [part-time; full-time] for the [employer] listed on this application [and</p>	<p>Either included or deleted from the</p>

<p>that my spouse is not currently disabled or unable to work].</p>	<p>enrollment form based on the needs of the prospective policyholder.</p>
<p><b>Things to Consider Before Replacing Your Existing Insurance Coverage</b></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>