City of Fort Collins

Aflac

CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION

Please Mail: PO Box 84078, Columbus, GA 31993

800.433.3036

HEALTH COVERAGES: THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Critical Illness		

Endorsement:

EFFECTIVE DATE:

FOR AGENT USE ONLY

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

Deduction start date _____

Applicant Name (First, MI, Last)		Employee ID #	Gender	DOB
Street Address	City		State	ZIP
Group Policyholder **City of Fort Collins #24228**	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 CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

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

Applicant Face Amount: $	Applicant cost per pay period: $
Spouse Face Amount: $	Spouse cost per pay period: $
	TOTAL cost per pay period: $

STATEMENT OF INSURABILITY

COMPLETE FOR GROUP CRITICAL ILLNESS INSURANCE AMOUNTS REQUESTED ABOVE GUARANTEE ISSUE AMOUNT

		Applicant	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 of the skin.	☐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
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?	☐YES ☐NO	☐YES ☐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?	☐YES ☐NO	☐YES ☐NO
6	Have you ever received any advice, treatment or consultation for a diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's disease) or multiple sclerosis?	☐YES ☐NO	☐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.

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's Printed Name_____

Agent No._____ State of Enrollment_____
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.