CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail: Post Office Box 84078
Columbus, GA 31993-4078
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Critical Illness		
Hospital Indemnity		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY

☐ **Initial Enrollment** ☐ **New Hire** ☐ **Re-Enrollment** ☐ **Newly Eligible** ☐ **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**
City and County of Broomfield #17601			

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?	☐ **YES** ☐ **NO**	
Are you now disabled or unable to 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**

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:** $_____

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)?	☐ **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.	☐ **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**

HOSPITAL INDEMNITY Plan: 1 ☐ 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?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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_____