

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

YES
 YES

NO
 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.

Notice: You should have comprehensive health coverage before purchasing this type of coverage.

Date _____ Signature of Applicant _____

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