



**EMPLOYEE APPLICATION
/STATEMENT OF INSURABILITY**
Please Mail To: P.O. Box 84078
Columbus, GA 31993 800.433.3036

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

Applicant Name (First, MI, Last)		Social Security # or ID #	Gender	Date of Birth
Street Address		City	State	ZIP
Group Policyholder Spokane Regional Emergency Communications #25802	Class Occupation	Location		Date of Hire
E-mail address	Hours Worked per Week	Daytime Phone No.		
Spouse's* Name (if coverage is requested)		Spouse's Gender	Spouse's Date of Birth	

*Spouse includes Domestic Partner pursuant to RCW 48.21.900.

Beneficiary Name/Relationship (estate unless designated otherwise)

	Applicant	Spouse
Are you actively at work?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Is your spouse now disabled or unable to work?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you or your spouse used tobacco products in the last 12 months?	YES NO	YES NO

GROUP CRITICAL ILLNESS INSURANCE Applicant Applicant and Spouse Family

Section 125: Yes No New Coverage Change in Coverage

With Cancer: yes

With Health Screening Benefit: yes

Applicant Face Amount:

Applicant cost per pay period:

Spouse cost per pay period:

Spouse Face Amount:

Total cost per pay period:

Heart Event Rider Progressive Diseases Rider Occupational HIV Rider Additional Benefits Rider

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)?	<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 of the skin.	<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 a diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's Disease) or multiple sclerosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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 Critical Illness insurance policy?
 YES NO

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.

Coverage will not become effective unless you are actively at work on the Certificate Effective Date. If you are not actively at work on that date, coverage will become effective on the date you return to an active work status.

CERTIFICATION: I have read the completed Employee Application/Statement of Insurability and the statements and answers that pertain to me and my spouse. I certify that these statements and answers are true and complete to the best of my knowledge and belief, and that the statements and answers will be used by the insurance company to determine insurability. I realize any false statement or misrepresentation in the Employee Application/Statement of Insurability may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application/Statement of Insurability 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 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 and that I have accurately disclosed my usage of tobacco products in the last 12 months.

If applying for spouse coverage, I certify that my spouse is not currently disabled or unable to work and that I have accurately disclosed my spouse's usage of tobacco products in the last 12 months.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Date Signature of Applicant

Date Signature of Insurance Producer Insurance Producer No.

State of Enrollment

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