



Coverage underwritten by
**CONTINENTAL AMERICAN
LIFE 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
Critical Illness		
Endorsement:		

EFFECTIVE DATE:

Employee Name/Owner (First, MI, Last)		S.S.N./ ID Number		Gender	Date of Birth
Street Address		City		State	Zip
Employer Southeastern California Conference of SDA		Job Class	Location		Date of Hire
Hours Worked	Daytime Phone No. ()	Beneficiary Name / Relationship (estate unless designated otherwise)			
*Spouse's Name (if coverage is requested)		Gender	*Spouse Date of Birth		
*Spouse includes Domestic Partner as defined in California Family Code Section 297.			Employee	*Spouse	
Are you currently working 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

CRITICAL ILLNESS Employee Employee & *Spouse

Employee Face Amount: \$ _____ **Employee Cost per pay period:** \$ _____

*Spouse Face Amount: \$ _____ ***Spouse Cost per pay period:** \$ _____

		Employee	*Spouse
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)? California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.	<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
3	Have you ever been treated for or diagnosed with 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

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: _____

Does the person to be insured have comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? YES NO *Persons without such comprehensive coverage are not eligible for coverage.*

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application that was made with actual intent to deceive Continental American Insurance Company 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.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

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 and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance.

Deduction start date _____

Any person who knowingly and with intent to defraud an insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concealing any fact material thereto commits a fraudulent insurance act, which is a crime.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ Agent # _____ State of Enrollment _____