



EMPLOYEE APPLICATION
 Please email: lee@vbs-
 benefits.com or fax
 1-801-944-0641

Continental American Insurance
 Company's state of domicile is
 Nebraska.

FOR HOME OFFICE USE ONLY				
PLAN	PLAN CODE		ID NUMBER	
Accident				
Critical Illness				
Hospital Indemnity				
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"/> New 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 Davis School District #3793	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?		<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

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	To the best of your knowledge, in the last 7 years, have you 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	To the best of your knowledge, 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	To the best of your knowledge, in the last 7 years, have you 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

GROUP HOSPITAL INDEMNITY INSURANCE

New Coverage Change in Coverage Increase/Buy-Up

Applicant Applicant & Spouse Applicant & Children Family

Cost Per Pay Period: _____

If **NOT** Guaranteed Issue, answer the following questions:

		Applicant	Spouse	Children
1	To the best of your knowledge, in the last 7 years, have you 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	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	To the best of your knowledge, 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.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	To the best of your knowledge, in the last 7 years, have you 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	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	To the best of your knowledge, 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

HEALTH COVERAGES:

Does this coverage replace or change any existing insurance? YES NO

If yes, please 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 Accident Hospital Indemnity

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.

A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an application or filing a claim that contains any false or deceptive statement.

The certificate provides limited benefits. Review your certificate carefully.

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.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

