

PLAN	FOR HOME OFFICE USE ONLY PLAN CODE	ID NUMBER
Critical Illness	FEAN CODE	ID NOMBER
Accident		
Endorsement:		1

	TITAL.	Citio	ui iiiiioss									
		B Accid	lent									
	NTINENTAL AMERICAN SURANCE COMPANY	Endor	Endorsement:									
i i	ENROLLMENT FORM											
Ple	ease Mail: Post Office Box 427											
	lumbia, South Carolina 29202		OTUE DAT	- 5%								
Emplo	yee Name/Owner (First, MI, Last)		EFFECTIVE DATE: S.S.N./ ID Number				r	Gender Date		Date of	Birth	
Street	Address			City					State		Zip	
Emplo	yer			Job Cla	ass		Location	1			Date of	Hire
Hours	S Worked Daytime Phone f	No. Ben	eficiary Name	e / Relatio	onship (es	tate ur	nless designa	ted othe	erwise)			
Spous	se's Name (if coverage is requeste	d)			Gende	er	Spouse Dat	e of Bir	th			
						-		Em	ployee		Spot	ıse
	you actively at work?		0.000.00000000004.0040/11/4-649.0		CONTRACTOR STATE		2000	ΠY	ES NO	-		
Are y	ou now hospitalized or una List all eligible cl							Vounc	net to Ol			□ №
	Name	Gender	Date of		osing c		ame	roung	Gende			te of
											Birth	
		8	Time	f C-								
	ADITION III NEGO				verage		<u>-</u> 20					V-100 COS
1	CRITICAL ILLNESS Employee Face Amount: \$_ Spouse Face Amount: \$		17	loyee C	Employe ost per p at per pay	ау ре	eriod: \$		Section —	125:	□ Yes	□No
9			, , , , , , , , , , , , , , , , , , ,						Employe	e	Spc	use
1a	Have you used tobacco pi	roducts in the I	ast 12 mor	nths?				1	YES [-	10.5%	□ NO
1b	Have you ever been treate for Acquired Immune Defi	ed for or diagno ciency Syndro	for or diagnosed by a member of the medical profession ncy Syndrome (AIDS) or "AIDS" Related Complex									ПИО
1c	in the last of Jersey and the last of the											
malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia lymphoma, or malignant tumor? Cancer does not include basal cell or squamo carcinoma.									YES 🗆	NO	□ YES	□ NO
1d	Have you ever been treate							art				
	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)								□ YES	□ NO		
	disease; c) organ transpla	int; d) emphyse	ema or e) r	now tak	ing 3 or	more	medication	ns				
	for high blood pressure?											
	\$			vo toni i					Castian	405		E N-
2	ACCIDENT 24 Hour	☐ Non-Occupa	tional Plai	n 1					Section	125	□Yes	LI NO
	□ Employee □ Employe	e & Spouse D	1 Employee	& Child	dren 🗆	Fam	nily	Cost	per pay pe	riod.	: \$	
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 f		ting insuran	ce? 🗖	YES 🗆	МО						
200	TIFICATION: I have read the c		ation and Lr	realize a	ny falee s	tatem	ent or micre	nrecer	atation in th	a 2n	nlication	max
result	t in loss of coverage under the ssary premium is paid.	certificate. I un	derstand tha	at no ins	urance w	ill be i	in effect unti	l my ap	pplication is	app	roved a	nd the
Cove	rage will not become effective	unless you are a	actively at w	ork on t	he date o	fthe	enrollment a	nd the	effective da	ate o	f covera	ige.
I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.												
	orize my employer to deduct t ance Company the premium re									al Aı	merican	
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.												
Date_	Signature of A	pplicant										
Date	Signature of A	aont				۸۵	ient#		State of F	proll	mont	