

ENROLLMENT FORM



For Home Office Use Only	
ID#	_____
Plan Code:	_____
Effective Date	_____

Post Office Box 8749
Columbia, South Carolina 29202 (866) 849-2953

1	Employee / Member Name	Social Security Number	Date of Birth	Gender
2	Street Address	City	State	Zip Code
3	Employer / Plan Sponsor Name	Date of Hire	Occupation	Hours worked per week <input type="checkbox"/> FT <input type="checkbox"/> PT
4	Home Phone Number	Beneficiary Name & Relationship		

Are you actively at work? YES NO

5	<input type="checkbox"/> Individual Only <input type="checkbox"/> Individual + Spouse <input type="checkbox"/> Individual + Children <input type="checkbox"/> Family			
Please list all covered dependents (Spouse and/or Children) below:				
	Name	Date of Birth	Name	Date of Birth
Spouse			Child	
Child			Child	
Child			Child	

HOSPITAL INDEMNITY COVERAGE

6	<input type="checkbox"/> Plan # _____ with: <input type="checkbox"/> Term Life (or) <input type="checkbox"/> Accidental Death	Monthly Premium: \$ _____
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CRITICAL ILLNESS COVERAGE – elect plan type and benefit amount

7a	<input type="checkbox"/> Individual Only <input type="checkbox"/> Individual + Spouse (Spouse coverage = 50% of employee Critical Illness benefit)			
7b	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other: _____	Monthly Premium: \$ _____		

8	<p>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.</p> <p>CERTIFICATION: The undersigned applicant has read the completed application and realizes that 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 until my application is approved and the necessary premium is paid.</p> <p>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.</p> <p>Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.</p> <p>Date _____ Signature of Applicant: _____</p> <p>Date _____ Signature of Agent: _____</p> <p>Agent's Name _____ Agent License Number _____ Company Code _____</p>
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USNOW1(FL) 08-03

THIS IS NOT BASIC HEALTH INSURANCE OR MAJOR MEDICAL COVERAGE AND IS NOT DESIGNED AS A SUBSTITUTE FOR BASIC HEALTH INSURANCE OR MAJOR MEDICAL COVERAGE.