



EMPLOYEE APPLICATION

Please Mail: Post Office Box 427
Columbia, South Carolina 29202
800.433.3036

FOR HOME OFFICE USE ONLY				
PLAN	PLAN CODE	ID NUMBER		
<i>Accident</i>				
<i>Critical Illness</i>				
<i>Disability Income</i>				
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 _____				

Employee Name/Owner (First, MI, Last)		Social Security Number/ID Number		Gender	Date of Birth
Street Address		City		State	ZIP
Employer City and Borough of Juneau #20386		Job Class/Occupation	Location		Hire/Change of Status Date
Hours Worked	Daytime Phone Number ()	Beneficiary Name/Relationship (estate unless designated otherwise)			
Spouse's Name (if coverage is requested)		Gender	Spouse's Date of Birth		
			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	

List all eligible children for whom you are proposing coverage (from Youngest to Oldest):

Name	Gender	Date of Birth	Name	Gender	Date of Birth

ACCIDENT	<input checked="" type="checkbox"/> Non-Occupational
<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family	Cost per pay period: \$ _____

CRITICAL ILLNESS	<input type="checkbox"/> Employee <input type="checkbox"/> Employee and Spouse
Employee Face Amount: \$ _____	Total cost per pay period: \$ _____
Spouse Face Amount: \$ _____	Spouse cost per pay period: \$ _____

		Employee	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.	<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

DISABILITY INCOME

If you answer "no" to the following questions, you will not be eligible for coverage:

Are you currently working full-time for at least 19 hours per week for the Employer listed above?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you earn at least \$9,000 base annual pay working for your Employer, the Policyholder?	<input type="checkbox"/> YES <input type="checkbox"/> NO

	Elimination Period: Accident: 0 days	Sickness: 7 days
Non-Occupational	Benefit Period:	3 months
	Monthly Benefit Amount:	\$
Annual Salary:	Cost per pay period:	\$

	Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation, or a similar law in your job with the Employer listed on this application?	<input type="checkbox"/> YES <input type="checkbox"/> NO
1	What is your current height and weight?	_____ ft _____ in _____ lbs
2	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
	In the last 2 years have you been diagnosed, received medical advice, sought treatment (including surgery), or taken medication for 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; e) High blood pressure, resulting in your now taking 3 or more medications for treatment; or f) 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
4	In the past 12 months, have you for any reason — other than colds, flu, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy — had a 20% or more reduction in hours for 5 or more consecutive days due to a muscular injury or disorder of the neck, back, shoulder, knee, or other joint?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	In the last 2 years have you been treated for — or counseled for — alcohol or drug abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	Have you, in the last 5 years: a) had your driver's license suspended or revoked, b) been charged with operating a motor vehicle while under the influence of drugs or alcohol, and/or c) been involved in 3 or more motor vehicle accidents?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	In the past 5 years have you been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following: a) Systemic lupus or other connective tissue disease, fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, disc disease, or joint replacements; b) Multiple sclerosis, muscular dystrophy or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), or Huntington's disease; c) Schizophrenia, psychosis, major depressive disorder, bipolar disorder, or post-traumatic stress disorder; or d) Alzheimer's disease, dementia, organic brain disease, or memory loss?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	In the past 2 years, have you had, or been treated for, or been told by a Doctor that you have: a) Neck, back, joint, bone, muscle, or tendon injury (excluding sprains or strains treated for less than 3 weeks or fractures not treated surgically); or b) Carpal Tunnel Syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO

This employee application is not complete unless signed and dated as indicated.

To the best of my knowledge and belief, the answers to the questions on this Employee Application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

Does this coverage replace any existing Aflac individual policy? YES NO

If Yes, please identify which product:

- Critical Illness
- Accident
- Disability

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

If yes, provide carrier and policy number: _____

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.

Coverage will not become effective unless you are employed full-time on the enrollment date and on the effective date.

CERTIFICATION: I have read the completed Employee Application and I realize any false statement or misrepresentation in the Employee Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application 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 my employer 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 currently work full-time for the employer listed on this Employee Application and that my spouse is not currently disabled or unable to work.

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.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ Agent No. _____ State of Enrollment _____

BI-WEEKLY RATES

AFLAC GROUP CRITICAL ILLNESS

- Current certificateholders use the Buy Up rates when adding additional coverage. If you're interested in increasing your Critical Illness benefit amount, contact your benefits administrator.

Employee / Bi-Weekly Rates								
AGES	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000
18-29	\$2.08	\$3.35	\$4.62	\$5.89	\$7.16	\$8.43	\$9.69	\$10.96
30-39	\$2.98	\$5.15	\$7.32	\$9.49	\$11.66	\$13.83	\$15.99	\$18.16
40-49	\$5.36	\$9.90	\$14.45	\$18.99	\$23.54	\$28.09	\$32.63	\$37.18
50-59	\$9.21	\$17.61	\$26.01	\$34.41	\$42.81	\$51.21	\$59.61	\$68.01
60-69	\$16.46	\$32.10	\$47.75	\$63.39	\$79.04	\$94.69	\$110.33	\$125.98

Employee and Spouse / Bi-Weekly Rates								
AGES	\$5k/\$5k	\$10k/\$5k	\$15k/\$7.5k	\$20k/\$10k	\$25k/\$12.5k	\$30k/\$15k	\$35k/\$17.5k	\$40k/\$20k
18-29	\$4.16	\$5.43	\$7.33	\$9.24	\$11.14	\$13.05	\$14.94	\$16.85
30-39	\$5.96	\$8.13	\$11.38	\$14.64	\$17.89	\$21.15	\$24.39	\$27.65
40-49	\$10.72	\$15.26	\$22.08	\$28.89	\$35.72	\$42.54	\$49.35	\$56.17
50-59	\$18.42	\$26.82	\$39.42	\$52.02	\$64.62	\$77.22	\$89.82	\$102.42
60-69	\$32.92	\$48.56	\$72.03	\$95.49	\$118.97	\$142.44	\$165.90	\$189.37

Employee / Bi-Weekly Buy Up Rates								
AGES	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000
18-29	\$1.27	\$2.54	\$3.81	\$5.08	\$6.35	\$7.62	\$8.88	\$10.15
30-39	\$2.17	\$4.34	\$6.51	\$8.68	\$10.85	\$13.02	\$15.18	\$17.35
40-49	\$4.55	\$9.09	\$13.64	\$18.18	\$22.73	\$27.28	\$31.82	\$36.37
50-59	\$8.40	\$16.80	\$25.20	\$33.60	\$42.00	\$50.40	\$58.80	\$67.20
60-69	\$15.65	\$31.29	\$46.94	\$62.58	\$78.23	\$93.88	\$109.52	\$125.17

Spouse / Bi-Weekly Buy Up Rates								
AGES	\$5k/\$5k	\$10k/\$5k	\$15k/\$7.5k	\$20k/\$10k	\$25k/\$12.5k	\$30k/\$15k	\$35k/\$17.5k	\$40k/\$20k
18-29	\$2.54	\$3.81	\$5.71	\$7.62	\$9.52	\$11.42	\$13.33	\$15.23
30-39	\$4.34	\$6.51	\$9.76	\$13.02	\$16.27	\$19.52	\$22.78	\$26.03
40-49	\$9.09	\$13.64	\$20.46	\$27.28	\$34.10	\$40.92	\$47.73	\$54.55
50-59	\$16.80	\$25.20	\$37.80	\$50.40	\$63.00	\$75.60	\$88.20	\$100.80
60-69	\$31.29	\$46.94	\$70.41	\$93.88	\$117.35	\$140.82	\$164.28	\$187.75

AFLAC GROUP ACCIDENT

Bi-Weekly Rates	
Coverage	Premium
Employee	\$7.01
Employee & Spouse	\$11.43
Employee & Child	\$13.72
Family	\$18.14

AFLAC GROUP DISABILITY

Age	Bi-Weekly Premium
18-49	\$1.17
50-64	\$1.25
65-74	\$1.48

*Disability rates are per \$100 of coverage