CONTINENTAL AMERICAN INSURANCE COMPANY

APPLICATION FORM FOR CRITICAL ILLNESS

Name (Employee)	Social Security Number	Sex	Date of Birth

Street Address	Apt. #	City	State	Zip Code	Phone Number ( )

Occupation	Date of Hire	Hours Worked per week	Beneficiary Name / Relationship

Spouse Name	Spouse Social Security No.	Sex	Date of Birth

Coverage:

Employee ☐ Tobacco ☐ Non-Tobacco Face Amount $ ________ * Premium $________ monthly

Spouse ☐ Tobacco ☐ Non-Tobacco Face Amount $ ________ * Premium $________ monthly

Child(ren) Coverage (each dependent child may be insured at 10% of the primary insured amount at no additional charge)

(List Dependent Children)

Dependent Name	Relationship	Date of Birth

MEDICAL QUESTIONS

1. Is any person to be insured now being treated for or has any person ever been treated for: (a) cancer or any malignancy which includes melanoma, carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor. Cancer does not include basal cell or squamous cell carcinoma; (b) a stroke; (c) a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease); (d) diabetes; (e) any liver disorder; (f) kidney (renal) failure or end stage kidney (renal) disease; (g) organ transplant; (h) emphysema; (i) or now taking three or more medications for high blood pressure?

   Employee ☐Yes ☐No **Spouse** ☐Yes ☐No **Child(ren)** ☐Yes ☐No

2 Is any person to be insured now being treated or has ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever been tested positive for antigens or antibodies to an "AIDS" virus?

   Employee ☐Yes ☐No **Spouse** ☐Yes ☐No **Child(ren)** ☐Yes ☐No

3. Is any person be insured now hospitalized or unable to perform their normal duties and activities?

   Employee ☐Yes ☐No **Spouse** ☐Yes ☐No **Child(ren)** ☐Yes ☐No

***Questions 4-8 must be completed if Employee is applying for benefits over $30,000 and/or if Spouse benefits over $15,000**

4. Employee Height / Weight ____ ft. ___ in. ______ lbs. Spouse Height / Weight ____ ft. ___ in. ______ lbs.

5. Has any person to be insured been hospitalized as an inpatient or outpatient for a sickness other than pregnancy at any time during the last five years?

   Employee ☐Yes ☐No **Spouse** ☐Yes ☐No **Child(ren)** ☐Yes ☐No

6. Has any person to be insured been advised to have any diagnostic test, hospitalization, surgery or treatment which has not been completed?

   Employee ☐Yes ☐No **Spouse** ☐Yes ☐No **Child(ren)** ☐Yes ☐No

7. Has any person to be insured had a weight loss of 10 pounds or more, other than by dieting, in the past 6 months?

   Employee ☐Yes ☐No **Spouse** ☐Yes ☐No **Child(ren)** ☐Yes ☐No

8. Has any person to be insured ever had, or taken prescription drugs for high blood pressure?

   Employee ☐Yes ☐No **Spouse** ☐Yes ☐No **Child(ren)** ☐Yes ☐No

Explantion of "YES" Answers:

CAIC02-SI-KS

This application is not complete unless signed and dated on the reverse side

IMPORTANT NOTICE

Required by Federal Law 91-508

(to be delivered to the applicant in connection with application(s) for insurance)

This is to inform you that as part of our normal underwriting procedure for processing your initial insurance application, an investigative consumer report may be prepared whereby information obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have a right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. Please direct any such request to Continental American Insurance Company, 2801 Devine Street, Columbia, South Carolina 29205.

See Reverse Side

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. It is understood and agreed that coverage will not become effective unless I am actively at work on the date of enrollment and the effective date of coverage.

Do you understand and agree that no benefits are payable for loss or disability starting or occurring within 12 months of the effective date of coverage which is caused by, contributed to by, due to or resulting from a Pre-existing condition, unless you have gone 12 months without medical care, treatment or supplies for the Pre-Existing Condition ☐ **YES** ☐ **NO**

CERTIFICATION: The undersigned applicant has read the completed application and that the applicant realizes that any false statements 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.
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement maybe guilty of insurance fraud.

The authorization on this application form shall remain valid for two years from the date of this application.

Date____________________ **Signature of Applicant**____

HOME OFFICE USE ONLY

☐ Simplified Issue *☐ Simplified Underwritten - Issued* *☐ Fully Underwritten*

Requested Effective Date ____________________ *Plan Code(s)* __________ *ID Number*____________

Effective Date __________________ *Leslie & Associates Benefit Alliance Company Code #* _____________