

# 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?  

<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child(ren)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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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?  

<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child(ren)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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3. Is any person be insured now hospitalized or unable to perform their normal duties and activities?  

<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child(ren)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**\*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?  

<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child(ren)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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6. Has any person to be insured been advised to have any diagnostic test, hospitalization, surgery or treatment which has not been completed?  

<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child(ren)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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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?  

<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child(ren)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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8. Has any person to be insured ever had, or taken prescription drugs for high blood pressure?  

<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child(ren)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Explanation of "YES" Answers:**

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

CAIC01-SI-KS

#### 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

**AUTHORIZATION:** I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person, that has any medical or non-medical record or knowledge of me, or members of my family for whom application has been made, to give Continental American Insurance Company any such information. A photographic copy of the authorization shall be as valid as the original. I hereby authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to Equifax, Inc. This agency is employed by Continental American Insurance Company to collect and send such information.

**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** \_\_\_\_\_

<b>HOME OFFICE USE ONLY</b>		
<input type="checkbox"/> <i>Simplified Issue</i>	<input type="checkbox"/> <i>Simplified Underwritten - Issued</i>	<input type="checkbox"/> <i>Fully Underwritten</i>
<i>Requested Effective Date</i> _____	<i>Plan Code(s)</i> _____	<i>ID Number</i> _____
<i>Effective Date</i> _____	<i>Leslie &amp; Associates Benefit Alliance Company Code #</i> _____	

CAIC01-SI-KS

**DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Continental American Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim of benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts, 02112, Telephone Number (617) 426-3660.

Continental American Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.