CONTINENTAL				FOR HOME OFFICE USE ONLY									
AMERICAN INSURANCE			PLA	AN	PLAN CODE		E	ID NUMBER					
COMPANY		Accident											
		IROLLMENT FORM	Critical Illness										
				Hospital Indemnity Endorsement:									
		ng out this form	Endors	semen	t:								
þ		k to the following number:											
		number:)1-944-0641											
			EFFECTIVE DATE:										
	nrollment pl	ny questions regarding lease call the following	FOR AGENT USE ONLY										
		er service number: 01-942-1043	☐ Initia	al Enrol	Ilment D	lew Hire C	Re-Enrollment	☐ New Elig	jible [⊒ Re-Sı	ubmissi	on	
		JI-342-1043		Deduction start date									
Empl	oyee Name/	Owner (First, MI, Last)	.1			Social S	Security Number	/ID Number	Gender Date of Birth				
Ctron	t Address				City				State	ZIP			
Stree	t Auuress				City				State	ZIF			
Empl		ool District #3793			Job Class/O	ccupation	Location		Hire/Cha	ange of S	Status Da	ite	
	s Worked	Daytime Phone Number	В	enefici	arv Name/Rel	ationship (es	tate unless des	anated otherwi	se)				
		()		0110	ury mannenne			giiatoa ett	,				
Spou	se's Name ((if coverage is requested)				Gender	Spouse's Date	of Birth					
•													
								Employ	Employee Spouse				
Are you currently working full-time for the			he emplo	ne employer listed above?					□ YES □ NO				
, vi <u>C</u>	Are you now disabled or unable to worl								☐ YES ☐ NO				
Are	you now d												
Are	you now d e you used	d tobacco products in the	last 12 ı		ns?			☐ YES ☐		□ YE	ES 🗆 N		
Are	you now d e you used	d tobacco products in the	last 12 i	m yo	ns? ou are prop	oosing co			t to Olde	□ YI est):	ES 🗆 N	0	
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ACC Cost CRIT	CIDENT mployee FICAL ILL ew Coverage Have you of Syndrome In the last carcinoma	d tobacco products in the tall eligible children for the tall	e last 12 ifor who for who Gender Diption I Employe Employe Sosed by a complex (A ated for or ase, leuke	pom yo Date Date Dee & Cl Doloyee Heart Doloyee Doloyee Heart H	and Spouse Rider ⊠ Inc. e cost per paragraph of the cost per paragra	Coverage family With cident Rider ay period: y period: al for Acquire ncer or any	Name □ Change in 0 □ Change in 0 □ Cancer: ☑ Ye s ed Immune De malignancy, inc	Coverage ficiency [Gende	ee NO D	Spous	o Sirth	

This enrollment form is not complete unless signed and dated as indicated.

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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 heartery 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 treat 	□ YES □ NO	□ YES □ NO							
но	SPITAL INDEMNITY Plan: 1									
ПΝ	ew Coverage									
		t per pay perio	d: \$							
Not ben	ice to Buyer for Hospital Indemnity Coverage: This is a Hospital Confinement Indemnity efits. Benefits are supplemental and are not intended to cover all medical expenses. Re	certificate. Thi	s certificate prov	rides limited						
If N	OT Guaranteed Issue, answer the following questions:									
		Employee	Spouse	Children						
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	□ YES □ NO	YES 🗆 NO	□ YES □ NO						
2	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	□ YES □ NO	D S INO	□ YES □ NO						
3	Have you ever been treated for a) a stroke, a heart attack, a 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) now taking 3 or more medications for high blood	□ YES □ NO	O U YES U NO	□ YES □ NO						
4	pressure? Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	□ YES □ NO	O D YES D NO	□ YES □ NO						
To the best of my knowledge and belief, the answers to the questions on this Enrollment Form are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. Does this coverage replace or change any existing insurance? 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.										
may	RTIFICATION: I have read the completed Enrollment Form and I realize any false statement result in loss of coverage under the Certificate. I understand that no insurance will be in enecessary premium is paid.									
I un	derstand and agree that the coverage that I am applying for may have a pre-existing condit	ion exclusion.								
	thorize my employer to deduct the appropriate dollar amount from my earnings each pay pen pany the required premium for my insurance.	eriod to pay Cor	ntinental America	n Insurance						
ins	erson is guilty of insurance fraud if he intends to defraud an insurer or if he urer. Fraudulent activities include submitting an Application or filing a claim tement.									
The Certificate provides limited benefits. Review your certificate carefully.										
Date	e Signature of Applicant									
Date	e Signature of Agent Agent No	State	of Enrollment							

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