Employee Survey

Please complete the following interest form. Please give us your best contact information so an insurance agent can speak with you about the policies and services that are being made available.

Completing this form does not imply coverage or issuance of an insurance policy.

Name: _____ **E.E.#** _____ **Gender:** _____

Address: _____ **Date of Birth:** _____ **State Born:** _____

City: _____ **State:** _____ **Zip Code:** _____

Employer: _____ **Job Title:** _____ **Hire Date:** _____

Best Phone#: _____ **E-Mail Address:** _____

Spouse's Name: _____ **Date of Birth:** _____

Names of dependent children between 0-25 (include name/gender/birth date):

_____

_____

_____

_____

Charles County, Maryland

Group Accident Insurance

High Option – 24 Hour Plan	**Semimonthly (24pp/yr)**
Employee	$7.41
Employee & Spouse	$10.26
Employee & Dependent Children	$13.60
Family	$16.45

Wellness Benefit included in Rates

Group Critical Illness Maryland - Semi-Monthly (24pp/yr)

NONTOBACCO - Employee						
AGES	$ 5,000	$10,000	$15,000	$ 20,000	$ 25,000	$ 30,000
18-29	$ 1.22	$ 1.87	$ 2.52	$ 3.17	$ 3.82	$ 4.47
30-39	$ 1.75	$ 2.92	$ 4.10	$ 5.27	$ 6.45	$ 7.62
40-49	$ 2.90	$ 5.22	$ 7.55	$ 9.87	$ 12.20	$ 14.52
50-59	$ 5.00	$ 9.42	$ 13.85	$ 18.27	$ 22.70	$ 27.12
60-69	$ 8.77	$ 16.97	$ 25.17	$ 33.37	$ 41.57	$ 49.77

NONTOBACCO - Spouse						
AGES	$ 5,000	$ 10,000	$ 15,000	$20,000	$25,000	$30,000
18-29	$ 1.22	$ 1.87	$ 2.52	$ 3.17	$ 3.82	$ 4.47
30-39	$ 1.75	$ 2.92	$ 4.10	$ 5.27	$ 6.45	$ 7.62
40-49	$ 2.90	$ 5.22	$ 7.55	$ 9.87	$ 12.20	$ 14.52
50-59	$ 5.00	$ 9.42	$ 13.85	$ 18.27	$ 22.70	$ 27.12
60-69	$ 8.77	$ 16.97	$ 25.17	$ 33.37	$ 41.57	$ 49.77

TOBACCO - Employee						
AGES	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$ 1.65	$ 2.72	$ 3.80	$ 4.87	$ 5.95	$ 7.02
30-39	$ 2.57	$ 4.57	$ 6.57	$ 8.57	$ 10.57	$ 12.57
40-49	$ 5.45	$ 10.32	$ 15.20	$ 20.07	$ 24.95	$ 29.82
50-59	$ 9.40	$ 18.22	$ 27.05	$ 35.87	$ 44.70	$ 53.52
60-69	$ 16.87	$ 33.17	$ 49.47	$ 65.77	$ 82.07	$ 98.37

TOBACCO - Spouse						
AGES	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$ 1.65	$ 2.72	$ 3.80	$ 4.87	$ 5.95	$ 7.02
30-39	$ 2.57	$ 4.57	$ 6.57	$ 8.57	$ 10.57	$ 12.57
40-49	$ 5.45	$ 10.32	$ 15.20	$ 20.07	$ 24.95	$ 29.82
50-59	$ 9.40	$ 18.22	$ 27.05	$ 35.87	$ 44.70	$ 53.52
60-69	$ 16.87	$ 33.17	$ 49.47	$ 65.77	$ 82.07	$ 98.37

Rates include Cancer Benefit
Rates Include: $50 Health Screening, CBP, and no additional Riders
No Benefit Reduction at age 70

Aflac.

CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION

Please Mail: PO Box 84078,
Columbus, GA 31993
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY				
☐ **Initial Enrollment**	☐ **New Hire**	☐ **Re-Enrollment**	☐ **Newly Eligible**	☐ **Re-Submission**
Deduction start date _____				

Applicant Name (First, MI, Last)	Social Security # or ID #	Gender	Date of Birth
Street Address	City	State	ZIP
Group Policyholder **Charles County Government #20458**	Class Occupation	Location	Date of Hire
E-mail address (optional)	Hours Worked per Week	Daytime Phone No.	

Spouse's Name (if coverage is requested)	Spouse's Gender	Spouse's Date of Birth
	Applicant	
Are you actively at work?	☐ **YES** ☐ **NO**	

Beneficiary Information – Employee's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

Beneficiary Information– Spouse's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

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

Name	Gender	Date of Birth	Name	Gender	Date of Birth

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

ACCIDENT

☐ New Coverage ☐ Change in Coverage ☐Increase/Buy-Up

☐ Employee ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Cost per pay period:

$_____

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

If yes, provide carrier: _____

Are you currently covered under, or does this coverage replace, an Aflac individual Accident insurance policy?

☐ **YES** ☐ **NO**

If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.

I have considered all of my existing health insurance coverage with Aflac and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac at 1-800-992-3522 regarding my individual policy and for assistance in evaluating the suitability of my insurance coverage.

If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify the company.

To the best of my knowledge and belief, my answers to the questions are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. I realize 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 unless I am actively at work on the effective date of coverage, and until my application is approved and the necessary premium is paid. If I am not actively at work on the effective date of coverage, coverage will become effective on the date I return to an active work status.

I authorize the Group Policyholder 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 am actively at work.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____

Agent's Printed Name_____

Agent No._____ State of Enrollment_____

Aflac

CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail: Post Office Box 427
Columbia, South Carolina29202
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Critical Illness		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)	S.S.N./ ID Number	Gender	Date of Birth
Street Address	City	State	Zip
Employer **Charles County Government #20458**	Job Class	Location	Date of Hire
Hours Worked	Daytime Phone No. ( )	Beneficiary Name / Relationship (estate unless designated otherwise)	
Spouse's Name (if coverage is requested)	Gender	Spouse Date of Birth	

	Employee	Spouse
Are you actively at work?	☐ YES ☐ NO	
Have you used tobacco products in the last 12 months?	☐ YES ☐ NO	☐ YES ☐ NO

CRITICAL ILLNESS ☐ Employee ☐ Employee & Spouse

Employee Face Amount: $_____ ***Employee Cost per pay period:*** $_____ ☐ Add-a-buck

Spouse Face Amount: $_____ ***Spouse Cost per pay period:*** $_____

		Employee	Spouse
1	In the last 7 years have you 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
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	☐ YES ☐ NO

3	In the last 7 years have you been treated for or diagnosed with 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 pressure?	☐ YES ☐ NO	☐ YES ☐ NO

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.

Are you currently covered under, or does this coverage replace, an Aflac individual Critical Illness insurance policy?
☐ YES ☐ NO

If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.

I have considered all of my existing health insurance coverage with Aflac and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac at 1-800-992-3522 regarding my individual policy and for assistance in evaluating the suitability of my insurance coverage.

CERTIFICATION: I have read the completed application and I realize 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.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

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 and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance.

Deduction start date_____

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent _____ Agent # _____ State of Enrollment_____

Aflac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name _____
Last First MI

SSN/Emp. ID _____

I hereby authorize my employer:

_____,

employer Payroll Account No. _____, to deduct from my earnings such amounts as may now or hereafter be payable by me under the insurance plan purchased through Aflac. In the event of a rate change, I authorize a corresponding change in the amount deducted from my earnings.

In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.

Signature of Applicant _____ Date _____

WAIVER OF PARTICIPATION

I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely.

I understand that these policies are offered through my employer by payroll deduction.

☐ I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time.

☐ I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction _____

Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD		NEW	
	AFTER-TAX	PRE-TAX	AFTER-TAX	PRE-TAX
☐ Other _____	$_____	_____	$_____	_____
☐ Cancer/Specified-Disease _____	$_____	_____	$_____	_____
☐ Return of Premium Rider _____	$_____	_____	$_____	_____
☐ Dental _____	$_____	_____	$_____	_____
☐ Vision _____	$_____	_____	$_____	_____
☐ Hospital Intensive Care _____	$_____	_____	$_____	_____
☐ Specified Health Event _____	$_____	_____	$_____	_____
☐ Hospital Confinement Indemnity _____	$_____	_____	$_____	_____
☐ Accident _____	$_____	_____	$_____	_____
☐ Disability Rider _____	$_____	_____	$_____	_____
☐ Short-Term Disability _____	$_____	_____	$_____	_____
☐ Life _____				
Employee	$_____	_____	$_____	_____
Dependent	$_____	_____	$_____	_____
TOTAL	$_____	_____	$_____	_____

The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above.

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.

COMMUNICORP, INC. • COLUMBUS, GA (706) 324-1182 183989

PAYROLL ACCOUNT