CONTINENTAL AMERICAN INSURANCE COMPANY

300 Southborough Drive, Suite 200, South Portland, Maine 04106

EMPLOYEE ENROLLMENT FORM FOR GROUP LIFE , AND AD&D , SHORT TERM AND LONG TERM DISABILITY INSURANCE

This Area for Agent or Plan Administrator Use Only.

Group Number(s):	Effective Date of Coverage: The first day of October, 2020 Month Year

To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed and dated by the Applicant.

Failure to sign and date this application and to accurately complete the questions on this application may affect the existence or amount of coverage.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender ☐ M ☐ F	Social Security No.

Home Address Number/Street	City	State	Zip

Home Phone Number ( )	Employer Name Advanced Industrial Services	Your Work Location/Site

Date of Hire	Occupation	Annual Income $	Your scheduled work hours per week

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.

MY SIGNATURE ON THIS APPLICATION REPRESENTS THAT:

1. I authorize my employer's Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and Continental American Insurance Company, and are to be paid to Continental American Insurance Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. To revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions. I must abide by any rules specified by the employer's benefit plan and/or by law.
2. I am applying for the coverages designated for which I am eligible under my employer's plan with Continental American Insurance Company.
3. All of the information on this application is complete, correct and true to the best of my knowledge and belief.
4. I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work. I also understand that dependent coverage will not become effective while the dependent is in a hospital or similar facility.
5. **FOR LIFE/AD&D INSURANCE:** I designate the beneficiary(ies) named in the beneficiary section of this application to receive any benefits payable in the event of my death.

NOTICE: For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

The insurance applied for shall be in force as of the date described in the certificate provided Continental American Insurance Company approves my application without any modifications as to the plan amount or premium. If the

application is approved with any modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me. Furthermore, the insurance shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.

Dated at: _____ On: _____/_____/_____
City State Month Day Year

_____ _____
Signature of Employee Printed Name of Employee

_____ _____
Enroller/Agent Agent Number

All applicants must complete this page to request coverage.

Employee Last Name	First Name	Middle Initial	Social Security No.

Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Total Amount Of Coverage Applied For	If (I) Or (D), My Prior Coverage Was
Life Employee ☐ Yes ☐ No			
Life Spouse ☐ Yes ☐ No			
Life Dependent Children ☐ Yes ☐ No		☐ $10,000	
AD&D: Employee ☐ Yes ☐ No (Must be equal to amount of Employee Life Insurance election)			
AD&D: Spouse ☐ Yes ☐ No (Must be equal to amount of Spouse's Life Insurance election)			
AD&D Dependent Children ☐ Yes ☐ No (Must be equal to amount of Child's Life Insurance election)		☐ $10,000	

Spouse Name (last, first, middle initial)	Spouse Gender M ☐ F ☐	Spouse Birth Date (MM/DD/YY)	Spouse Social Security No.

Dependent Child(ren)'s Name(s) (last, first, middle initial)	Date(s) of Birth

Has Employee (applicant) used cigarettes or other tobacco products in the last 12 months?	☐ Yes ☐ No
Has Spouse used cigarettes or other tobacco products in the last 12 months?	☐ Yes ☐ No

NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES

Information regarding your insurability will be treated as confidential. Continental American Insurance Company or its representatives may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone number: 866-692-6901.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Continental American Insurance Company, 300 Southborough Drive, Suite 200, South Portland, ME 04106.

Life and AD&D Insurance Beneficiary Designation

Employee Last Name	First Name	Middle Initial	Social Security No.

If your designation does not fit into one of the sections below, please contact your HR representative or Continental American Insurance Company (the "Company") for assistance. Please return your completed Beneficiary Designation form to your Agent or Employer.

Please complete only one of the four sections below and then sign and date the bottom of this page. Please read the second page and supply the information requested if you chose #1 ("Individual(s)") on this page.

☐ 1**. INDIVIDUAL(S)**

PRIMARY BENEFICIARY(IES)	All beneficiaries in this section will be considered primary. Proceeds will be paid in equal shares to primary beneficiaries who survive you unless you indicate percentages. Percentages must equal 100%.

NAME	DATE of BIRTH	SSN	RELATIONSHIP	PERCENTAGE
1.				
2.				
3.				

SECONDARY BENEFICIARY(IES)	All beneficiaries in this section will be considered secondary. If no primary beneficiaries survive you, proceeds will be paid to the surviving secondary beneficiaries named in this section. Payment will be paid in equal shares unless you indicate percentages. Percentages must equal 100%.

NAME	DATE of BIRTH	SSN	RELATIONSHIP	PERCENTAGE
1.				
2.				
3.				

☐ 2**. TRUSTEE UNDER TRUST AGREEMENT**

To _____
NAME OF TRUSTEE

of _____, or successor, as trustee under a trust agreement
CITY STATE

of _____
NAME OF SETTLOR, GRANTOR, DONOR

Dated _____, as amended.

☐ 3**. TRUSTEE UNDER WILL**

To the trustee under my last will and testament, including any codicil thereto

☐ 4**. ESTATE OF INSURED**

To the executors or administrators of my estate

ANY AMOUNT OF INSURANCE PAYABLE AT MY DEATH SHALL BE PAYABLE AS INDICATED ABOVE

Signature _____ Date _____

LIFE and AD&D Insurance Beneficiary Designation – General Provisions

Employee Last Name	First Name	Middle Initial	Social Security No.

A. Please provide the name, address and telephone number of each beneficiary named in section 1 on the first page of this form.

B. If there is no beneficiary entitled to payment in accordance with the designation, payment will be made to the spouse of the insured if living; otherwise, in equal shares to the then living children of the insured, if any; or, if none, to the father and mother of the insured, in equal shares or to the survivor of them; or, if none, to the executors or administrators of the insured's estate.

C. Continental American Insurance Company will make payment to the trustee under the insured's last will and testament if it receives at its home office, within one year after the date of the insured's death, evidence satisfactory to it that the trustee is authorized to receive payment under applicable law. If no evidence is received within that period, payment will be made to the executors or administrators of the insured's estate.

D. Payment to any trustee in accordance with the designation will discharge Continental American Insurance Company to the extent of such payment, and Continental American Insurance Company will not be responsible for the proper discharge of the trust or any of its terms.

E. If any Primary or Secondary Beneficiary dies before the insured, then that beneficiary's share will be distributed equally among the other surviving beneficiaries within the same Primary or Secondary designation, unless the insured indicates otherwise in writing.

Name _____ Name _____

Address _____ Address _____

_____ _____

Telephone Number_____ Telephone Number_____

Name _____ Name _____

Address _____ Address _____

_____ _____

Telephone Number_____ Telephone Number_____

Name _____ Name _____

Address _____ Address _____

_____ _____

Telephone Number_____ Telephone Number_____

IMPORTANT NOTICE TO APPLICANTS ---- PLEASE READ CAREFULLY

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION
FOR INSURANCE UNDERWRITING PURPOSES

This authorization excludes psychotherapy notes.
This authorization complies with the HIPAA Privacy Rule.

I authorize any licensed physician, any other medical practitioner or provider, pharmacy, pharmacy benefit manager, pharmacy related service organization, hospital, clinic, other medical or medically related facility, Medical Information Bureau, laboratory, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Continental American Insurance Company (the "Company"), *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) that may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by the Company and its representatives to evaluate my application for insurance and may be redisclosed to any organization or person employed by or representing the Company solely to assist with this purpose. I give my permission to the Company, its representatives and its reinsurers to release any information to other insurance companies with which I may come in contact. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy Rule.

This authorization will remain in effect a maximum of six (6) months from the date of the signature below. A photocopy of this authorization is as valid as the original. I have the right to request and receive a copy of this authorization and the information to which it pertains.

I have the right to revoke this authorization by notifying the Company or its representatives in writing. However, such revocation is not effective to the extent that the Company or its representatives have relied upon this authorization for the use or disclosure of my information pursuant to this authorization. Failure to sign this authorization may impair the Company's and its representatives' ability to evaluate my application. As a result, failure to sign may be a basis for denying my application for insurance coverage.

* **Wisconsin**: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV). **Maine**: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive, but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this provision will prohibit this authorization from including the fact that the applicant has AIDS. **Vermont**: This authorization EXCLUDES the release of any information about previously administered HIV-related tests including, but not limited to, tests for HIV antibodies, T-Cell counts, AIDS or ARC.

I have read the NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES and the AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FOR INSURANCE UNDERWRITING PURPOSES. I have made a copy of my application for my records. I have read the Statement of Insurability and all of the statements and answers. To the best of my knowledge and belief, all statements made on this application are true and complete. I understand that my statements and answers will be used to determine insurability and coverage will be accepted or declined on the basis of these statements.

The following general fraud notice applies: *Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.*

Dated at: _____ On: _____/_____/_____
City State Month Day Year

_____ _____
Signature of Employee Printed Name of Employee

_____ _____
Signature of Spouse Printed Name of Spouse