CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEEAPPLICATION/ STATEMENT OF INSURABILITY

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Hospital Indemnity		
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 **MDA Insurance and Financial Group #24672**	Class/Occupation	Location	Date of Hire
E-mail address	Hours Worked per Week	Daytime Phone No.	
Spouse's Name (if coverage is requested)		Spouse's Gender	Spouse's Date of Birth
Beneficiary Name/Relationship (estate unless designated otherwise)			

	Applicant	**Spouse**
Are you actively at work?	☐ **YES** ☐ **NO**	
Have you or your spouse used tobacco products in the last 12 months?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

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

Name	Gender	Date of Birth	Name	Gender	Date of Birth

HOSPITAL INDEMNITY Plan: 81000

☐ New Coverage ☐ Change in Coverage

☐ Employee ☐ Employee & Spouse ☐ Employee & One Dependent ☐ Employee & Children ☐ Family

Cost per pay period: $_____

Base Plan (check one) ☐ High ☐ Mid ☐ Low

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

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 (CAIC) as the basis for any insurance issued.
Does this coverage replace any existing Aflac individual policy? ☐ **YES** ☐ **NO**
Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**

If yes, provide carrier and policy number: _____
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.

If applicable, I understand I must notify CAIC in writing when coverage on all dependent children terminates as specified in the certificate or a rider.

Coverage will not become effective unless you are actively at work on the Certificate Effective Date. If you are not actively at work on that date, coverage will become effective on the date you return to an active work status.

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to CAIC as the basis for any insurance issued. I realize any fraudulent 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 date of enrollment and the effective date of coverage, and until my application is approved and the necessary premium is paid.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize the Group Policyholder to deduct the appropriate dollar amount from my earnings each pay period to pay CAIC the required premium for my insurance.

I certify that I am actively at work. If applying for spouse coverage, I certify that my spouse is not currently disabled or unable to work.

I understand and agree that my certificate may be issued to me in an electronic format. I agree to receive communication about this coverage through email.

I have received an Outline of Coverage applicable to the coverage being applied for.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____

Agent's Printed Name_____

Agent No._____ State of Enrollment_____

Return completed application to:

mda insurance®
MDAPROGRAMS.COM

Via mail to MDA Insurance, 3657 Okemos Road, Suite 100, Okemos MI 48864.

Via email to tvoss@mdaifg.com or via fax at 517-484-5460.