Life Insurance Conversion Application for an Individual Whole Life Policy

Continental American Insurance Company ("CAIC" or "The Company")
P.O. Box 427, Columbia, SC 29202

Mail Form To Paylogix LLC FBO Aflac PLADS P.O. Box 1625 New York, NY 10008-1625	**Toll Free Phone:** 800-206-8826

Instructions on Completing the Form

Complete this form when you elect to convert your group term life insurance ("Prior Plan") to an individual policy underwritten by Continental American Insurance Company ("CAIC"). It must be completed in full and submitted to the Conversion Unit address within the Election Period stated in Section 2.

Brief Description of Conversion Privilege: Subject to the terms of your Prior Plan as described in your group insurance certificate 1) you or an eligible dependent may apply for an individual life insurance policy without medical evidence of insurability; and 2) the individual policy may be for the same amount of insurance lost, or for a lesser amount.

Employer (policyholder or recordkeeper):

1. Complete all of Section 1 when coverage terminates or reduces.
2. Provide a copy to your employee on or before the employee's termination date.
3. Retain a copy for your records.

Policy Owner:

1. Review all of Section 1 for accuracy.
2. Complete all of Sections 2 through 5.
3. Submit the completed and signed application, together with the premium payment to CAIC.
4. Maintain a copy of this completed form for your records.

Section 1 – Completed by the Employer (Policyholder and/or Recordkeeper)

Employer Group Name	Group Number		Division Department
Employer Address	City	State	ZIP
Policy Number	Policy Effective Date		Date of Birth
Insured First, M.I., Last Name	SSN		Gender □ M □ F
Occupational Title	Scheduled Work Hours (per week)		Insured's Effective Date
Insurance Class	Annual Salary/Earnings		Date Employment Began
Date Coverage Began	Date Last Worked	Date Written Notice of conversion right given to employee	
If notice not provided, state why	If Supplemental Insurance is selected, please provide date of last increase		

Reason for Coverage Termination □ Job Termination □ Retirement □ No Longer Eligible	Was the insured actively at work on termination date? □ Yes □ No Has a Waiver of Premium claim been submitted? □ Yes □ No

Provide Amount of Insurance Terminated

Amount of Basic Life Coverage Employee: $ Spouse: $ Child(ren): $	Amount of Optional Life Coverage Employee: $	Amount of Dependent Life Coverage Spouse: $ Child(ren): $

Provide Amount of Insurance Remaining In Force When Reduced or Terminated

Amount of Basic Life Coverage Employee: $ Spouse: $ Child(ren): $	Amount of Optional Life Coverage Employee: $	Amount of Dependent Life Coverage Spouse: $ Child(ren): $

Employer Group Contact First, Last Name	Employer Group Contact Email Address	
Employer Contact Title	Date Signed	Federal Employer ID Number

Section 2 – Election Form: To Be Completed by the Proposed Policy Owner

Election Period: This application must be submitted within 31 days of a benefit reduction, or termination of your Prior Plan. It may be submitted within any extension period provided by your Prior Plan. No medical exam or evidence of insurability is required to elect this policy.

Policy Owner First, M.I., Last Name	SSN	Date of Birth	Age
Policy Owner Mailing Address	City	State	ZIP
Policy Owner Primary Phone	Policy Owner Mobile Phone	Policy Owner Email Address	

New Coverage Amount(s)

Proposed Insureds:	**Yourself**	**Dependent Spouse**	**Dependent Child(ren)**
New Coverage Amount Selected	□ $ □ No Coverage	□ $ □ No Coverage	□ $ □ No Coverage
Smoker Status Required if applying for Whole Life option	□Smoker □Non-Smoker	□Smoker □Non-Smoker	

Spouse Information (Applicable If Applying for Spouse Coverage)				
Insured First, M.I., Last Name	Social Security Number	Gender □ M □ F	Date of Birth	Age
Child(ren) Information (Applicable If Applying for Child(ren) Coverage)				
Insured First, M.I., Last Name	SSN	Gender □ M □ F	Date of Birth	Age
Insured First, M.I., Last Name	SSN	Gender □ M □ F	Date of Birth	Age
Insured First, M.I., Last Name	SSN	Gender □ M □ F	Date of Birth	Age
Insured First, M.I., Last Name	SSN	Gender □ M □ F	Date of Birth	Age
Insured First, M.I., Last Name	SSN	Gender □ M □ F	Date of Birth	Age

Section 3 – Beneficiary Information: To Be Completed by Policy Owner

Primary				
First, M.I., Last Name	Relation to Insured	SSN	DOB	PCT%
First, M.I., Last Name	Relation to Insured	SSN	DOB	PCT%
First, M.I., Last Name	Relation to Insured	SSN	DOB	PCT%
Contingent				
First, M.I., Last Name	Relation to Insured	SSN	DOB	PCT%
First, M.I., Last Name	Relation to Insured	SSN	DOB	PCT%
First, M.I., Last Name	Relation to Insured	SSN	DOB	PCT%

If two or more primary beneficiaries are named, and you do not list percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%.

Section 4 – Agreement and Signature: To Be Completed by Policy Owner

By signing below I acknowledge that I understand and agree:

1. CAIC will have no liability until:
   a. A policy is issued on this application and delivered to the owner; and
   b. The first premium due is paid in full while each proposed insured is alive.
2. The statements in this application are the basis for any policy issued by CAIC, and no information provided by an applicant will be considered to have been given to CAIC unless it is stated in the application. I will notify The Company of any changes in the statements given in the application between the time of application and delivery of the policy.
3. No person other than an Officer of CAIC can make, modify, or discharge a policy or contract or waive any of CAIC's rights or requirements.
4. That issuance of the individual policy applied for shall be exchanged for all privileges and benefits with respect to the full amount of term life insurance in force at the time of termination or reduction, on my life, under my Prior Plan with CAIC less any amount of group life insurance remaining in force.
5. The converted individual policy will have different terms and conditions than the coverage I had under my Prior Plan.
6. If CAIC accepts this application, such approval shall be based upon the above statements and answers, which shall be deemed to be representations and not warranties.
7. The effective date of the individual conversion policy shall be the date of termination of coverage under the group policy.

By signing below, I apply for the insurance policy selected in Section 2 for the proposed insured(s) identified in Section 2 in accordance with the provisions of my Prior Plan. I request this transaction be completed by the Company on behalf of myself and all of my heirs, beneficiaries, assignees and any others claiming under the above policy. The application will be attached to the policy when issued.

I have read, or have had read to me, the application including all of the statements and the answers as they pertain to them. I represent that these statements and answers are true and complete to the best of my knowledge and belief.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

You must pay the first premium due when you submit this application.

Premium Payment Type / Submitted Premium Amount	Premium Payment Frequency
□ EFT (paper-free billing process) $_____ □ Check $_____	□ Monthly (EFT Only) □ Quarterly □ Semi-Annually □ Annually
Signature of Proposed Insured	**Date** **Signed at City, State**
Signature of Proposed Owner (*if other than Proposed Insured*)	**Date** **Signed at City, State**

Signature of Parent or Legal Guardian	Date
	Signed at City, State

Section 5 – Payment Authorization Agreement for Continental American Insurance Company

□ **I choose to pay by electronic draft.**

Account Holder's Name			
Insured Mailing Address	City	State	ZIP

Routing Transit Number	Account Number
___ ___ ___ ___ ___ ___ ___ ___ ___ □ Checking □ Savings	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

I authorize The Company to electronically debit my account for premium payments in accordance with the frequency chosen in this Application. If the account does not have sufficient funds, CAIC may, but is not required to, try again. I understand if the account does not have sufficient funds, and premium is not paid before the expiration of the grace period insurance will be terminated. I agree this authorization will remain in effect until I provide CAIC at least 31 days prior written notice of its termination.

Account Holder's Signature	Date

Rate Sheet and Premium Calculation – Whole Life Conversion

Rates and Premium Calculation

Annual Rates* Per Thousand

**Rates are subject to change based on rate increases implemented without notice in accordance with state laws and regulations.*

Plus Annual Policy Fee: $75.36

<1	$ 6.31						
1	$ 6.56	26	$ 11.83	51	$ 48.07	76	$ 182.05
2	$ 6.71	27	$ 12.19	52	$ 51.67	77	$ 193.86
3	$ 6.97	28	$ 12.91	53	$ 54.89	78	$ 206.57
4	$ 7.22	29	$ 13.63	54	$ 58.49	79	$ 220.16
5	$ 7.37	30	$ 14.35	55	$ 62.42	80	$ 234.63
6	$ 7.62	31	$ 16.15	56	$ 66.02	81	$ 250.01
7	$ 7.88	32	$ 16.51	57	$ 69.96	82	$ 266.37
8	$ 8.13	33	$ 17.59	58	$ 73.92	83	$ 283.92
9	$ 8.38	34	$ 18.29	59	$ 79.30	84	$ 302.85
10	$ 8.68	35	$ 19.37	60	$ 84.67	85	$ 323.08
11	$ 9.04	36	$ 20.45	61	$ 85.27	86	$ 344.39
12	$ 9.34	37	$ 21.53	62	$ 85.87	87	$ 366.62
13	$ 9.69	38	$ 22.61	63	$ 86.47	88	$ 389.64
14	$ 10.00	39	$ 24.05	64	$ 92.21	89	$ 413.35
15	$ 10.35	40	$ 25.46	65	$ 97.58	90	$ 437.73
16	$ 10.75	41	$ 27.26	66	$ 102.74		
17	$ 11.16	42	$ 28.70	67	$ 108.25		
18	$ 11.47	43	$ 30.50	68	$ 114.17		
19	$ 11.47	44	$ 31.94	69	$ 120.57		
20	$ 11.47	45	$ 34.08	70	$ 127.51		
21	$ 11.47	46	$ 35.52	71	$ 135.03		
22	$ 11.47	47	$ 37.68	72	$ 143.11		
23	$ 11.47	48	$ 39.82	73	$ 151.75		
24	$ 11.47	49	$ 41.98	74	$ 161.07		
25	$ 11.47	50	$ 44.86	75	$ 171.15		

To Determine Your Initial Premium, Complete the Premium Calculation Worksheet

Please note, your coverage effective date is the first day following your conversion eligibility period, typically the 32nd day following the date your group coverage terminated. Example, coverage terminates on September 30, your coverage effective date would be November 1.

**Each covered child will have their own policy incurring an annual policy fee.*

Life Insurance	Yourself	Spouse	Child(ren)
1. Age			
2. Rate from table above			
3. Amount of Insurance			
4. Divide Line 3 by 1,000			

5. Multiply Line 4 by Line 2			
6. Each insured will be required to pay an annual policy fee of $75.36	**$75.36**	**$75.36**	**$75.36***
7. Add Line 5 and 6			
8. **For Monthly Premium:** Divide the amount in Line 7 by 365, then multiply by the number of days from coverage effective date to end of the current month to arrive at the initial monthly premium due. *Premiums are due on the 1st of the month			
9. **For Quarterly Premium**: Divide the amount in Line 7 by 365, then multiply by the number of days from coverage effective date to end of the current quarter to arrive at the initial quarterly premium due. *Quarterly premiums are due on January 1, April 1, July 1, October 1			
10. **For Semi-Annual Premium:** Divide the amount in Line 7 by 365, then multiply by the number of days from coverage effective date to end of the current semi-annual period to arrive at the initial semi-annual premium due. *Semi-annual premiums are due on January 1 and July 1			
11. **For Annual Premium:** Divide the amount in Line 7 by 365, then multiply by the number of days from coverage effective date to end of the current year to arrive at the initial annual premium due. *Annual premiums are due on January 1			
Total Initial Premium Due **Initial premium payable by check only**	**$**	**$**	**$**

Example Calculation of Annual Premium Based on Age (39 Years Old)

Age: 39
Rate: $24.05
Amount of Insurance $50,000
Divide $50,000 by 1,000 = 50
Apply Rate of $24.05 x 50 = $1,202.50 in annual premium
Plus $75.36 Annual Policy Fee = $1,277.86 (Annual Premium Due)