



## Benefit Services

New Mexico State University  
MSC 3HRS, Box 30001  
Las Cruces, NM 88003-8001  
Phone: (575) 646-8000  
Fax: (575) 646-2806

## AFLAC Critical Illness Instructions for New Enrollment

Regular and term appointment employees are eligible for this benefit. You must be less than age 70 at time of enrollment. Eligible dependents may include spouse, qualified domestic partner, children up to age 26, disabled children over age 26. Enrollment must be submitted to NMSU Benefits no later than 31 days from the official job start date/date of hire for guaranteed coverage. Coverage is effective on the first day of the month after the form is received, provided it is received by the 14<sup>th</sup> day of the month. Forms received more than 10 days after the signature date on the form will be voided and not processed.

Full details and brochure of Critical Illness plan our found on the NMSU Benefits website at <http://benefits.nmsu.edu/insurance/critical-illness/>.

### EMPLOYEE/SPOUSE INFORMATION

- Complete the information requested for employee
- If requesting spouse coverage, complete the information requested for spouse

### MANDATORY QUESTIONS

- Please answer questions by checking “YES” or “NO” in appropriate Employee/Spouse box:
  - Are you currently benefits eligible for the employer listed above? (Question for employee only)
  - Are you now disabled or unable to work? (Question for spouse only. Complete only if requesting coverage for spouse.)
  - Have you used tobacco products in the last 12 months? (Complete question for employee; if requesting coverage for spouse, also complete question for spouse.)

### CRITICAL ILLNESS SECTION

- If only employee is requesting coverage, check “Employee” box and include amount requested and cost per pay period for employee (See [Rates](#))
- If both employee and spouse are requesting coverage, check “Employee & Spouse” box and include amount requested and cost per pay period for both employee and spouse
- Check “Yes” or “No” if this coverage replace any existing Aflac individual policy or if this coverage will replace or change any existing insurance
  - If “Yes,” provide carrier policy and number
- Read certification statements
- Date
- Signature of Applicant (Employee)

The Critical Illness plan will cover dependent children, up to age 26, at 25% of the employee elected amount, at no additional cost. If you plan to cover your dependent children on your policy, please list their information below:

Last Name	First Name	Social Security Number	Gender	Date of Birth
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	

**\*Note – supporting documentation may be needed for adding spouse/domestic partner or dependent children**

**The completed form should be returned to: Benefit Services, PO Box 30001 MSC 3HRS, Las Cruces, NM 88003 or delivered to Hadley Hall Room 17**



**ENROLLMENT FORM**  
 Please Mail To: Post Office Box 427  
 Columbia, South Carolina 29202  
 800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
<b>Critical Illness</b>		
Endorsement:		
EFFECTIVE DATE:		
FOR AGENT USE ONLY		
Guaranteed Issue	<input type="checkbox"/> New Hire	or <input type="checkbox"/> Newly Eligible
Deduction start date _____		

Employee Name/Certificate Holder (First, MI, Last)		Social Security Number/ID Number	Gender	Date of Birth
Street Address		City	State	ZIP
Employer New Mexico State University #11833		Job Class/Occupation	Location	Hire Date/Change of Status Date
Hours Worked	Daytime Phone Number ( )	Beneficiary Name/Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse's Date of Birth	
		Employee	Spouse	
Are you currently benefits eligible for the employer listed above?		<input type="checkbox"/> YES <input type="checkbox"/> NO		
Are you now disabled or unable to work?				<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you used tobacco products in the last 12 months?		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

**CRITICAL ILLNESS**  Employee  Employee and Spouse With Cancer:  Yes

New Coverage  Change in Coverage

Employee Face Amount: \$ \_\_\_\_\_ Employee cost per pay period: \$ \_\_\_\_\_

Spouse Face Amount: \$ \_\_\_\_\_ Spouse cost per pay period: \$ \_\_\_\_\_

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.

Coverage will not become effective unless you are employed as benefits eligible on the enrollment date and on the effective date.

**CERTIFICATION:** I have read the completed Enrollment Form and I realize any false statement or misrepresentation in the Enrollment Form may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Enrollment Form 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 my employer to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime, and may be subject to civil fines and criminal penalties.**

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_ Signature of Agent \_\_\_\_\_ Agent No. \_\_\_\_\_ State of Enrollment \_\_\_\_\_

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