



**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 Late Enrollment

Regular and term appointment employees are eligible for this benefit. You must be less than age 70 at the time of enrollment. Eligible dependents may include spouse, qualified domestic partner, children up to age 26, disabled children over age 26. Enrollment forms received more than 10 calendar days after the signature date will be returned to the employee as invalid. The employee will be required to submit a new enrollment form to elect coverage. Late enrollment approval or denial is usually provided by Aflac within 60 days. Coverage is effective the first pay period after approval is received.

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
- **As a late enrollee, you will need to answer the 3 questions listed. If are applying for employee/spouse coverage, please answer 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**

# Aflac<sup>®</sup>

**CONTINENTAL AMERICAN  
INSURANCE COMPANY**  
**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		
<i>Critical Illness</i>				
Endorsement:				
EFFECTIVE DATE:				
FOR AGENT USE ONLY				
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> Newly Eligible	<input type="checkbox"/> Re-submission
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 <b>New Mexico State University #11833</b>		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		
			<b>Employee</b>	<b>Spouse</b>	
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:** \$ \_\_\_\_\_

		Employee	Spouse
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, 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) high blood pressure, resulting in your now taking 3 or more medications for treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

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 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.

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.

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 \_\_\_\_\_