



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 14th 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

Aflac
CONTINENTAL AMERICAN
INSURANCE COMPANY

EMPLOYEE APPLICATION
/STATEMENT OF INSURABILITY

Please Mail To: P.O. Box 84078
Columbus, GA 31993 800.433.3036

FOR HOME OFFICE USE ONLY				
PLAN	PLAN CODE	ID NUMBER		
Critical Illness				
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 _____				

Applicant Name (First, MI, Last)		Social Security # or ID #	Gender	Date of Birth
Street Address		City	State	ZIP
Group Policyholder New Mexico State University #11833	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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you or your spouse used tobacco products in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

GROUP CRITICAL ILLNESS INSURANCE Applicant Applicant and Spouse

New Coverage Change in Coverage

With Cancer: yes

With Health Screening Benefit: yes

Applicant Face Amount: \$ _____ **Applicant cost per pay period:** \$ _____

Spouse Face Amount: \$ _____ **Spouse cost per pay period:** \$ _____

Total cost per pay period: \$ _____

Heart Event Rider Optional Benefits Rider

Statement of Insurability			
Complete for Group Critical Illness Insurance Amounts Requested Above Guarantee Issue Amount			
		Applicant	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 of the skin.	<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

4	Have you ever received any advice, treatment, or consultation for: any disorder of the central nervous system, Parkinson's Disease, Alzheimer's Disease, dementia, senility, or organic brain syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	Have you ever received any advice, treatment or consultation for a diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's Disease) or multiple sclerosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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 Employee Application/Statement of Insurability and the statements and answers that pertain to me and my spouse. I certify that these statements and answers are true and complete to the best of my knowledge and belief, and that the statements and answers will be used by the insurance company to determine insurability. I realize any false statement or misrepresentation in the Employee Application/Statement of Insurability may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application/Statement of Insurability 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 Continental American Insurance Company the required premium for my insurance.

I certify that I am actively at work and that I have accurately disclosed my usage of tobacco products in the last 12 months.

If applying for spouse coverage, I certify that my spouse is not currently disabled or unable to work and that I have accurately disclosed my spouse's usage of tobacco products in the last 12 months.

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 civil fines and criminal penalties.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ Agent No. _____ State of Enrollment _____

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