Continental American Insurance Company | Columbia, South Carolina |1-800-433-3036 toll-free

Group Number: ______________________ Group Name: ____

Customer Name: ____

Date of termination from employer: ________________ Were you employed Part or Full Time? Check one ☐ Part-time ☐ Full-time

Termination Reason: ______________________ *(Examples: Disability, Group Canceled, Laid Off, New Job, Reduced Hours, Retired, Terminated, etc.)*

Customer Signature: ____ Today's Date: ____________________

(By signing the above, you agree to continue coverage on a direct bill basis for the products indicated below.)

Choose the plans you wish to continue and select the desired payment listed below:

Initial the box(es) below for the insurance plans you wish to continue.	**Type of Plan**	**Type of Coverage** *(Individual or Family)*	**Monthly Amount Due Per Plan**
	Accident		
	Cancer		
	Critical Illness		
	Hospital		
	Term Life		
	Whole life		
	Long Term Disability*		
	Short Term Disability*		

**For disability coverage to port, your former employer must have offered an active CAIC disability policy(ies) and you must currently be employed*

	I would like to pay *(Please check one)*	**Total Amount Due:**
	Monthly Draft	$
	Quarterly	$
	Semi-Annual	$
	Annual	$

Amount Enclosed: $_______________

If remitting this form *with* payment, please send to:

Aflac-CAIC
PO Box 641629
Pittsburgh, PA 15264-1629

If remitting this form without a payment, please send to:

Aflac Group Correspondence
PO Box 84079
Columbus, GA 31993-9101

PLEASE DO NOT STAPLE

Aflac
Worldwide Headquarters

Continental American Insurance Company | Columbia, South Carolina |1-800-433-3036 toll-free

AUTHORIZATION AGREEMENT FOR ACH DEBITS

I hereby request and authorize Continental American Insurance Company, a member of the Aflac family of companies, hereinafter called Company, to initiate ACH debit entries to my financial institution account indicated below and the financial institution named below to debit the same to such account.

This authority is to remain in full force and effect until the Company has received notification from me of its termination. I have the right to discontinue debit entry by giving written notice 10 business days prior to the scheduled draft date and send it to Aflac Group Correspondence PO Box 84079 Columbus, GA 31993-9101. I have the right to stop payment of a debit entry by notification to the financial institution at such time as to afford the financial institution a reasonable opportunity to act on it prior to charging the accounts.

Please include a voided check.

For Home Office Use Only

<Name>

Control Policy Number

#<certificate number>

_____

NAME OF FINANCIAL INSTITUTION

_____

ADDRESS

_____

CITY STATE ZIP CODE

_____ CHECKING/SAVINGS *(Circle type of account)*

TRANSIT/ABA NUMBER ACCOUNT NUMBER

_____

DATE SIGNATURE OF PREMIUM PAYOR