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
- Please answer questions 1-3 by checking "YES" or "NO" in appropriate Employee/Spouse box
- 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
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ 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

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***
Critical Illness		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY				
☐ **Initial Enrollment**	☐ **New Hire**	☐ **Re-Enrollment**	☐ **Newly Eligible**	☐ **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	**Job Class/Occupation**	**Location**	**Hire Date/Change of Status Date**
New Mexico State University #11833			

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?	☐ **YES** ☐ **NO**	
Are you now disabled or unable to work?		☐ **YES** ☐ **NO**
Have you used tobacco products in the last 12 months?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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)?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **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_____