



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*	☐	☐

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

Amount Enclosed: \$ _____

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

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 (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.



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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

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