



Continental American Insurance Company (CAIC) 1-866-849-0011

Complete the below and remit form with payment if you wish to PORT your coverage. Please ensure that return address shows in window.

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 Cancelled, Laid Off, New Job, Reduced Hours, Retired, Terminated, Resignation, etc.

Customer Signature: _____ Today's Date: _____

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

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

Initial the box(es) below of the items you wish to continue coverage	Type of Policy	Type of Coverage (Individual or family)	Monthly Amount Due Per Policy
<input type="checkbox"/>	Accident		\$
<input type="checkbox"/>	Cancer		\$
<input type="checkbox"/>	Critical Illness		\$
<input type="checkbox"/>	Hospital		\$
<input type="checkbox"/>	Term Life		\$
<input type="checkbox"/>	Whole Life		\$
<input type="checkbox"/>	Long Term Disability*		\$
<input type="checkbox"/>	Short Term Disability*		\$

*Disability not portable if group is not active

I would like to pay (Please check one)	Total Amount Due:
<input type="checkbox"/> Monthly Draft	\$
<input type="checkbox"/> Quarterly	\$
<input type="checkbox"/> Semi Annual	\$
<input type="checkbox"/> Annual	\$

Payment is due by: <today's date + 30 days>
Amount Enclosed: \$ _____

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 Continental American Insurance Company
 PO Box 641629
 Pittsburgh, PA 15264-1629



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 days prior to the scheduled draft date. 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.

<p>For Home Office Use Only</p> <p><Name></p> <p>Control Policy Number #<certificate number></p>
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NAME OF FINANCIAL INSTITUTION

ADDRESS

CITY STATE ZIP CODE

TRANSIT/ABA NUMBER ACCOUNT NUMBER CHECKING / SAVINGS
(Circle type of account)

DATE SIGNATURE OF PREMIUM PAYOR

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If you have any questions, please contact Customer Service Center at 1-866-849-0011.