



EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

LTD 1-800-753-0404

EMPLOYER INFORMATION

Legal Name of Employer _____ Tax I.D. Number _____
Address _____ City _____ State _____ Zip _____
Telephone () _____ Firm Contact _____ Title _____
(person to contact concerning coverages)
Employees Eligible: _____ # Eligible Employees Enrolled: _____ # Family Members in Firm: _____
Type of Business - i.e. sole proprietorship, partnership, corporation, etc.: _____
Effective Date Requested: _____ SIC Code or Nature of Business: _____
(The firm's effective date will be the first or the 15th of the month following written acceptance by Companion Life Insurance Company.)
How many years in this business? _____ How many years in this location? _____
Will this insurance replace existing insurance? _____ Name of existing carrier _____

Waiting Period Initial Enrollment Future Employees (Minimum 3 Months)
[] Immediately [] Other _____ [] 3 months [] Other _____

[] All Industry Plan
Benefit Percentage 60% of Earnings
Maximum Payment Amount \$6,000 per month
Benefit \$ _____
Elimination Period 180 Days
Maximum Payment Duration Two Years/RBD
Percent of premium paid by employer _____ %

[] 5 Year/Reducing Benefit Duration (RBD) Plan
Benefit Percentage 60% of Earnings
Maximum Payment Amount \$6,000 per month
Benefit \$ _____
Elimination Period [] 90 Days [] 180 Days
Maximum Payment Duration Five Years/RBD
Percent of premium paid by employer _____ %

[] Age 65/Reducing Benefit Duration (RBD) Plan
Benefit Percentage 60% of Earnings
Maximum Payment Amount \$6,000 per month
Benefit \$ _____
Elimination Period [] 90 Days [] 180 Days
Maximum Payment Duration Age 65/RBD
Percent of premium paid by employer _____ %

Are any of the persons to be covered retired, currently hospitalized, disabled or on any extension of benefits? [] Yes [] No (If yes, give details.)

FRAUD WARNING: (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING: (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Participation Agreement (administered and underwritten by Companion Life Insurance Company)

The Participant does hereby apply for Group Insurance Benefits as set forth in the above "Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

Name of Trust: Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does he have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy. The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202-3102, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666. The undersigned employer agrees that coverage shall not commence until this application has been approved by Companion Life Insurance Company and notice of approval has been transmitted to us. As named employer, I understand that I should not cancel any existing coverage until notified that this application has been accepted by Companion Life.

Signature of Applicant _____
Title _____ Date _____
Signature of Agent/Broker _____ Date _____
Printed Name _____

FOR HOME OFFICE USE
Accepted by Administrator Effective: _____
By: _____
Title _____ Date _____

**GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST**



- New Employee
- Add/Increase Coverage
- Change Beneficiary
- COBRA
- Change Address
- Change Dependent Coverage
- Change Class or Status
- Terminate Coverage

Companion Use Only
 Approved: Declined:
 Date: _____
 By: _____

TO BE COMPLETED BY EMPLOYER						Group No. (10 digit #)			DEPT/DIV (3 digit #)			CLASS					
Name of Employer (Use Name from Group Billing Notice or Master Application)																	
TO BE COMPLETED BY EMPLOYEES																	
Social Security Number			Effective Date			Date Employed Full Time			Date of Birth			Hours Worked Per Week					
			Month Day Year			Month Day Year			Month Day Year								
Your Name Last		First		M.I.		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		(Do not include over-time or bonuses.)							
Earnings \$																	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Occupation		Your Home Address				City		State		Zip Code					
COMPLETE FOR LIFE AND/OR DISABILITY																	
COVERAGE REQUESTED <input type="checkbox"/> Basic Life Insurance <input type="checkbox"/> AD&D <input type="checkbox"/> Dependent Life Insurance <input type="checkbox"/> Short Term Disability																	
<input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary LTD																	
<input type="checkbox"/> Voluntary Life																	
(Amount Selected) EMPLOYEE:			Life \$		AD&D \$		SPOUSE: Life \$			AD&D \$		CHILD: Life \$					
Spouse Name: Last			First		Middle		Birthdate			Social Security Number							
<i>(Voluntary Life Only)</i>																	
Beneficiary for Employee Coverage/Relationship: <i>(Employee is beneficiary for spouse coverage.)</i>																	
Last			First		Middle		Relationship to Insured										
COMPLETE FOR DENTAL AND/OR VISION																	
Coverage Requested: <input type="checkbox"/> Dental For Employee Only <input type="checkbox"/> Dental For Employee and Dependents																	
<input type="checkbox"/> Vision For Employee Only <input type="checkbox"/> Vision For Employee and Dependents																	
Is your spouse to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental and/or Vision Coverage Is For (Check Box Below):								Are you or any of your dependents covered for dental insurance under another policy? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		<input type="checkbox"/> Employee		<input type="checkbox"/> Employee plus Spouse		<input type="checkbox"/> Employee plus Child(ren)		<input type="checkbox"/> Family									
Complete for Dependent Coverage																	
Spouse Name (Last) (First) (Middle Initial)			Full-time Student Y/N		Date of Birth		Gender M or F		Do any of your dependents have any other dental coverage?			If Yes, Name of Carrier					
					/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No								
CHILDREN	1				/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No								
	2				/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No								
	3				/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No								
	4				/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No								

REFUSAL OF GROUP INSURANCE

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Coverage Refused (Check All That Apply): Basic Life AD&D Dependent Life Voluntary Life

Short Term Disability Long Term Disability Voluntary LTD Dental Voluntary Dental

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FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Your Signature
	X

NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.

Employee Name: _____ Employee SSN: _____
 Employee Date of Birth: _____ Group Name: _____ Group #: _____

You must provide the following health information to obtain the requested insurance coverage if:

(1) You are required by Companion Life to furnish evidence of insurability; (2) you previously declined or terminated coverage; or (3) (For Life, STD, LTD) your application for coverage is being made more than 31 days after you originally became eligible for this coverage. Please answer every question and complete every space. Complete for spouse and child(ren) (if applicable) if applying for Voluntary Life Insurance Coverage.

Name and address of the Doctor or facility that has your medical records.	Employee's Doctor: _____ Address: _____	Spouse's Doctor: _____ Address: _____	Child's Doctor: _____ Address: _____
Employee: Height: _____ Weight: _____ Have you gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds (Explain below.)	Spouse: Height: _____ Weight: _____ Have you gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds (Explain below.)		

Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required.	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
1. Within the past 10 years has the proposed Insured:						
a. Had an application for life or health insurance, or for reinstatement thereof, declined or modified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Applied for or received any disability compensation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Flown or intended to fly as a pilot, student pilot or crew member?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the proposed Insured smoked cigarettes in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you now actively employed on a full-time basis (30 hours or more per week)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. To the best of your knowledge and belief, do you have any physical impairment or disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Within the past 10 years, have you been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for:						
a. Coronary artery disease, abnormal blood pressure, diabetes or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genito-urinary or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Drug or alcohol dependency or abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any other abnormality, deformity, disease or disorder not recorded above, including accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been a patient in a hospital, sanitarium, or institution?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had any surgical operations or had surgery advised but not performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. To the best of your knowledge and belief, are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Give the name and address of your personal physician and the date and reason for your last consultation.	Name: _____ Address: _____ Date: _____ Reason: _____					
12. Details in connection with questions 3-8 answered "YES" above.						

Question No.	Name	Date Mo.	Yr.	Give Full Details for Each Question Answered "Yes" Including Nature of Illness or Injury, Number of Attacks, Duration, Severity, Treatment, Results and any Other Pertinent Information	Name and Address of Physician or Hospital

I have _____ (number) children eligible as defined in the group policy.
 All eligible children are free of any sickness, disease or injury, as defined in Questions 3 through 9 above, except as follows (Write "none" if all children do not need treatment or are free of impairments.): _____

I hereby certify that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning any proposed insured's past or present health has been omitted. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by Companion Life Insurance Company.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, Medicare Part A and Part B carrier that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give Companion Life Insurance Company or their reinsurers any such information. I understand that Companion Life insurance Company will collect this information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202. I understand that revocation may be a basis for denying insurance benefits or a claim for benefits. I understand that if I fail to sign this authorization Companion Life may not be able to evaluate or process my application or claim and may be a basis for denying my application or claim for benefits. I know that I have a right to receive a copy of this authorization upon request. A photostatic copy of this authorization shall be valid as the original.

Witness _____ Date _____ Signature of Proposed Insured (or, if below age 15, parent or guardian) _____ Date _____

PRE-NOTICE TO PROPOSED INSURED

Companion Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.