



EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

1-800-753-0404

EMPLOYER INFORMATION

Firm Name, Address, City, State, Zip, Telephone, Firm Contact, Title, Type of Business, # Full-time Employees in Firm, # Full-time Employees Enrolled, Effective Date Requested, SIC Code or Nature of Business, How many years in this business?, Tax I.D. Number, Will this insurance replace existing insurance?, Name of existing carrier, Which coverages are being replaced?

Life and AD&D options: Flat Amount Plan, Class Plan, Percent of premium paid by employer, Dependent Life, Spouse, Children, Children: 14 days - 6 months.

Waiting Period options: Initial Enrollment, Future Employees, One month, Other.

STD options: Percent of Earnings, 60% to a maximum benefit of, Benefit Period, Benefits Begin, Percent of premium paid by employer.

Table with 5 columns: Life and AD&D Total Monthly Premium, Dependent Life Total Monthly Premium, STD Total Monthly Premium, \$10.00 per month Administration Fee, Total Monthly Premium.

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.

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**



Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

- | | |
|--|--|
| <input type="checkbox"/> New Employee | <input type="checkbox"/> Change Address |
| <input type="checkbox"/> Add/Increase Coverage | <input type="checkbox"/> Change Dependent Coverage |
| <input type="checkbox"/> Change Beneficiary | <input type="checkbox"/> Change Class or Status |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> Terminate Coverage |

Companion Use Only	
Approved: <input type="checkbox"/>	Declined: <input type="checkbox"/>
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		
Your Name	Last	First	M.I.	Sex	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually (Do not include over-time or bonuses.)		Earnings \$ _____	
<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	Life	AD&D	Life	AD&D	Life
(Amount Selected) EMPLOYEE: \$ _____	\$ _____		SPOUSE: \$ _____	\$ _____	CHILD: \$ _____
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			Full-time	Date of Birth	Gender	Do any of your dependents have any other dental coverage?	If Yes, Name of Carrier
Spouse Name	(Last)	(First)	Student Y/N	/ /	M or F	<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):				
<input type="checkbox"/> Basic Life	<input type="checkbox"/> AD&D	<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Voluntary Life	
<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Voluntary LTD	<input type="checkbox"/> Dental	<input type="checkbox"/> 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: _____ Spouse's Doctor: _____ Child's Doctor: _____
 Address: _____ Address: _____ Address: _____

Employee: Height: _____ Weight: _____
 Have you gained or lost more than 20 pounds in the last year?
 Yes No
 If yes, amount gained or lost: _____ pounds
 (Explain below.)

Spouse: Height: _____ Weight: _____
 Have you gained or lost more than 20 pounds in the last year?
 Yes No
 If yes, amount gained or lost: _____ pounds
 (Explain below.)

	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.