

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		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 Student	Date of Birth	Gender M or F	Do any of your dependents have any other dental coverage?		If Yes, Name of Carrier
Spouse Name (Last)	(First)	(Middle Initial)		Y/N	/ /		<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												

FRAUD WARNING (Not Applicable in AZ, FL, GA, 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.

Date	Your Signature X
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DENTAL EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

EMPLOYER (APPLICANT) INFORMATION (Please Print or Type)

Legal Name of Employer _____

Type of Business (Sole Proprietorship, Partnership, Corporation, etc.) _____

Address _____ City _____ State _____ ZIP _____

Telephone (_____) _____ Contact _____ Title _____
(Person to contact concerning coverages)

No. of Eligible Employees : _____ No. of Eligible Employees Enrolled: _____

Effective Date Requested: _____ SIC Code and 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 at this location? _____

Tax I.D. Number: _____ No. of Family Members in Organization: _____

PLAN DESCRIPTION

PLAN REQUESTED:

- | | | | | | |
|----------------------------------|----------|----------|-----------|---|--|
| <input type="checkbox"/> Plan A: | I - 100% | II - 80% | III - 50% | - | \$1,000 Annual Maximum - \$100 Lifetime Deductible |
| <input type="checkbox"/> Plan B: | I - 100% | II - 80% | III - 50% | - | \$1,000 Annual Maximum - \$25/\$50 deductible |
| <input type="checkbox"/> Plan C: | I - 100% | II - N/A | III - N/A | - | \$1,000 Annual Maximum - \$15 copay per visit |
| <input type="checkbox"/> Plan D: | I - 100% | II - 80% | III - 50% | - | \$1,000 Annual Maximum - \$50 Contract Year Deductible |

Are Orthodontia Benefits requested? (Plans A, B and D only) Yes No

Are Takeover Benefits requested? Yes No If yes, please provide the following:

- a. Name of Prior Carrier: _____
- b. Effective Date of Prior Plan: _____ c. Termination Date of Prior Plan: _____

Also, submit a copy of your previous insurance carrier's most recent billing statement as well as a certificate or letter of acceptance that shows the effective date of your policy along with a copy of your previous carrier's certificate, booklet or schedule of benefits. If prior carrier's bill does not include the effective date of each employee's coverage, please note this information next to each employee's name so we can give the correct credit for transfer of benefits.

Employment Waiting Period: 1 Month Other: _____
(No waiting period applies to those employed on the effective date.)

Coverage following the completion of the waiting period selected will be effective on the first or the 15th of the month only.
The employer agrees to contribute the following percentage of the cost of employee dental insurance for all covered employees _____% (25% required)

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

Name of Trust: The Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee 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(ies). 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, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666.

(Signature of Employer/Applicant)

(Title) (Date)

This is to certify that I, the undersigned agent, have truly and accurately recorded on this application form the information supplied.

(Signature of Agent/Broker) (Date)

Print Agent/Broker's Name License No.

FOR HOME OFFICE USE

Accepted by Administrator Effective: _____

By: _____

(Title) (Date)