



VOLUNTARY DENTAL INSURANCE EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

EMPLOYER (APPLICANT) INFORMATION (Please Print or Type)

Legal Name of Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Contact: _____ Title: _____ (Person to contact concerning coverage)

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

Effective Date Requested: _____ SIC Code and Nature of Business: _____ (The effective date will be the first or 15th day of the calendar month coinciding with or next following the date of written acceptance by Companion Life.)

How many years in this business? _____ How many years at this location? _____

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

PLAN REQUEST: VOLUNTARY INDEMNITY GROUP DENTAL

- Companion Premier Plan (Basic, Preventive and Major Services)
Advantage Plan (Basic, Preventive and certain Major Services)
Companion Premier Plan (Basic, Preventive, Major and Orthodontic Services)

TAKEOVER BENEFITS: Apply only if prior plan was group, employee-paid dental coverage.

In order for Companion Life to determine whether or not Takeover Benefits are to be included, the following must be provided:

- Name of Prior Carrier: _____
Effective Date of Prior Plan: _____
Termination Date of Prior Plan: _____

The employer must also submit a copy of (1) the prior carrier's most recent billing statement; (2) a certificate or letter of acceptance that shows the effective date of the prior plan; and (3) the prior 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.

The normal work week for full-time employees is _____ hours.
Eligibility: All regular full-time employees working a minimum of _____ hours.
Employment Elimination Period: [] 1 Month [] Other: _____
(No elimination period applies to those employed on the effective date.)
(The minimum work week for full-time employees to be eligible for benefits is 30 hours.)
(Coverage following completion of the waiting period will be effective on the first or 15th day of the calendar month only.)

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 Employer hereby applies for Group Insurance Benefits as set forth in the above "Voluntary 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 the 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.
FOR HOME OFFICE USE ONLY
Employer Group No.: _____
Takeover Benefits: [] Yes [] No
Accepted by Companion Life 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 \$		Your Home Address		City		State		Zip Code				
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Occupation										

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 \$ Life AD&D \$ Life AD&D 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): <input type="checkbox"/> Employee <input type="checkbox"/> Employee plus Spouse <input type="checkbox"/> Employee plus Child(ren) <input type="checkbox"/> Family						Are you or any of your dependents covered for dental insurance under another policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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)	(Middle Initial)	Student Y/N	/ /	M or F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DEPENDENT	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

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.