



# Companion Life

Companion Life Insurance Company/Columbia, South Carolina  
P.O. Box 100102  
Columbia, SC 29202-3102

## VOLUNTARY GROUP TERM LIFE INSURANCE EMPLOYER PARTICIPATION APPLICATION

The undersigned Employer applies for membership in the Companion Life Joint Employer Group Insurance Trust and for participation in the insurance coverage now in effect or later modified.

1. Legal Name of Employer _____	2. Group Number _____						
3. Address _____							
4. Name of Subsidiaries, Divisions or Affiliates to be covered _____							
5. Name of Contact _____	6. Telephone Number (    ) _____						
7. Proposed Effective Date 12:01 A.M. _____	8. Nature of Business _____						
9. Will the employer contribute to the cost of the insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what percentage? _____%	10. Number of Employees Eligible _____    Enrolled _____						
11. Are any employees disabled at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, give details. Use additional sheet, if required. _____							
12. Is there any other insurance in force, being applied for or being issued at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details: _____ Is this insurance intended to replace any existing group life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, give details (company name, coverage termination date) _____							
13. Eligibility All regular full-time employees working a minimum of _____ hours per week (Not less than 30 hours per week). Are any employees excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please define: _____							
14. Eligibility Waiting Period A. All Employees: _____ B. Is waiting period waived for current employees? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Coverage effective: <input type="checkbox"/> First billing following or coincident with the end of the waiting period. <input type="checkbox"/> Day following waiting period (Premium will be prorated). <input type="checkbox"/> Other, specify _____							
15. Amount of Insurance: Employee <table style="width:100%; border:none;"> <tr> <td style="width:33%;"><b>Companion Choice Plus</b></td> <td style="width:33%;"><b>Companion Choice</b></td> </tr> <tr> <td><input type="checkbox"/> <b>Employee Life Insurance:</b> Option of \$10,000, or \$25,000 to \$300,000 in \$25,000 increments. (Maximum Benefit of 7 x salary)</td> <td><input type="checkbox"/> <b>Accidental Death and Dismemberment Insurance:</b> (The AD&amp;D amount will be the same as the Life Insurance amount. The AD&amp;D benefit is not available for children.)</td> </tr> <tr> <td><input type="checkbox"/> <b>Employee Life Insurance:</b> Option of \$10,000, \$25,000, \$50,000, \$75,000 or \$100,000.</td> <td></td> </tr> </table>		<b>Companion Choice Plus</b>	<b>Companion Choice</b>	<input type="checkbox"/> <b>Employee Life Insurance:</b> Option of \$10,000, or \$25,000 to \$300,000 in \$25,000 increments. (Maximum Benefit of 7 x salary)	<input type="checkbox"/> <b>Accidental Death and Dismemberment Insurance:</b> (The AD&D amount will be the same as the Life Insurance amount. The AD&D benefit is not available for children.)	<input type="checkbox"/> <b>Employee Life Insurance:</b> Option of \$10,000, \$25,000, \$50,000, \$75,000 or \$100,000.	
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16. Dependent Benefits: <table style="width:100%; border:none;"> <tr> <td style="width:33%;"><input type="checkbox"/> <b>Spouse Life Insurance:</b> Options of \$5,000 increments not to exceed 50% of the employee amount.</td> <td style="width:33%;"><input type="checkbox"/> <b>Dependent Life Insurance:</b> 6 months to age _____    Option of \$2,500, \$5,000, \$7,500 or \$10,000 If a full-time student; to age _____    (Employee coverage required). 14 days to 6 months:    10% of selected benefit.</td> </tr> </table> Evidence of Insurability will be required on Employee Life, Spouse Life and Dependent Life coverages based on participation.		<input type="checkbox"/> <b>Spouse Life Insurance:</b> Options of \$5,000 increments not to exceed 50% of the employee amount.	<input type="checkbox"/> <b>Dependent Life Insurance:</b> 6 months to age _____    Option of \$2,500, \$5,000, \$7,500 or \$10,000 If a full-time student; to age _____    (Employee coverage required). 14 days to 6 months:    10% of selected benefit.				
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17. Reduction: Employee Life Insurance benefit reduces to 65% at age 65, reduces to 50% of the original amount at age 70, to 35% at age 75, to 20% at age 80, and terminates at retirement, whichever occurs first. Spouse Life benefit reduces in accordance with the employee's reduction. It will terminate at age 70 or upon the employee's retirement, whichever occurs first. The Dependent Child benefits terminate upon termination of the employee's benefit.							

**EMPLOYER PARTICIPATION AGREEMENT**  
Administered and Underwritten by Companion Life Insurance Company

The Participating Employer does hereby apply for Voluntary Group Term Life Insurance as set forth in this request and subscribes to the Agreement and Declaration of Trust.

NAME OF TRUST: Joint Employer Group Insurance Trust

It is understood and agreed that all the following requirements shall be met:

1. The insurance shall not become effective unless this request is accepted and approved by the Administrator.
2. The Participating Employer will furnish and maintain the records necessary to the Administration of the Plan; will report changes to and from the group, will process claims promptly as they occur, and will make all premium payments in accordance with the terms of the Plan.
3. I understand that only permanent active employees, partners, and proprietors working the minimum hours shown on the Participation Agreement are eligible for coverage. I understand the Guarantee Issue limitation of the insurance plan and understand that the coverage is renewable at the option of the Underwriting Company.
4. I understand the underwriting and participation requirements, and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force.
5. Insurance coverage on any individual shall become effective on the first premium due date coinciding with, or next following, satisfaction of any waiting period and receipt and approval of proper enrollment material (including evidence of insurability, if required).
6. Any Employer or Member contributions will be collected by the Participating Employer. The Participating Employer agrees to remit these premiums on or before each premium due date to the Administrator or to its designated representative.

The Participating Employer acknowledges and warrants that coverage under any policy through the Joint Employer Group Insurance Trust shall only be as and to the extent provided in the insurance policy or policies held by the Trustee, and the Participating Employer has explained this to each person for whom it seeks benefits thereunder, and the Participating Employer further acknowledges and agrees that, notwithstanding the date of this application or the date when the Administrator may act hereon, coverage will commence only if this application is accepted by the Administrator and then only upon the effective date to be inserted by the Administrator in the acceptance form below. The Participating Employer further acknowledges and agrees that no one other than an executive officer of the Administrator or other person designated by the Administrator in writing to do so and acting at the Administrator's Office in Columbia, South Carolina may accept this application on behalf of the Joint Employer Group Insurance Trust.

The Participating Employer may withdraw from the Joint Employer Group Insurance Trust and cancel its application at any time upon thirty-one (31) days' prior written notice to the Administrator. Failure to remit and pay charges when due shall automatically constitute such withdrawal and cancellation of all coverage. In the event coverage is terminated because of non-payment of premium and the Participating Employer has not given thirty-one (31) days' written notice of such desire to cancel coverage, the Participating Employer shall be liable for all premiums that fall due for coverage provided during the thirty-one (31) day grace period following the last premium due date.

It is understood and agreed by the undersigned that the Trustee is not an insurer, and does not 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 Company 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 Participating Employer at the office of the Administrator, located at 7909 Parklane Road, Suite 200, Columbia, South Carolina. The Administrator may cancel the Participating Employer's application and membership in the Joint Employer Group Insurance Trust at any time upon 45 days' prior written notice to the Participating Employer.

The Participating Employer does herewith remit the sum of \$\_\_\_\_\_ on account of the first premium or the first and subsequent premiums on a policy of group insurance for which request has been made to Companion Life Insurance Company. If such Participating Employer is not approved or if for any reason the insurance applied for does not become effective, the amount paid in exchange for this receipt shall be refunded.

**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.

\_\_\_\_\_ (Company)

By: \_\_\_\_\_

\_\_\_\_\_ (Title) \_\_\_\_\_ (Date)

\_\_\_\_\_ Agent Name (Please print or type)

Accepted by Administrator	
By: _____	
_____ (Title)	_____ (Date)
Effective 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        |

<b>Companion Use Only</b>	
Approved: <input type="checkbox"/>	Declined: <input type="checkbox"/>
Date: _____	
By: _____	

<b>TO BE COMPLETED BY EMPLOYER</b>		Group No. (10 digit #)	DEPT/DIV (3 digit #)	CLASS
Name of Employer (Use Name from Group Billing Notice or Master Application)				

<b>TO BE COMPLETED BY EMPLOYEES</b>							
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"/> 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

<b>COMPLETE FOR LIFE AND/OR DISABILITY</b>						
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			

<b>COMPLETE FOR DENTAL AND/OR VISION</b>						
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	

<b>REFUSAL OF GROUP INSURANCE</b>		
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.

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 <i>yes</i> or <i>no</i> 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.