

**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 Month Day Year	Date Employed Full Time Month Day Year	Date of Birth Month Day Year	Hours Worked Per Week
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 Basic Life Insurance AD&D Dependent Life Insurance Short Term Disability
 Long Term Disability Voluntary LTD

Voluntary Life

Life AD&D	Life AD&D	Life
(Amount Selected) EMPLOYEE: \$ \$	SPOUSE: \$ \$	CHILD: \$

Spouse Name: Last First Middle Birthdate Social Security Number
(Voluntary Life Only)

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage.)*
 Last First Middle Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION

Coverage Requested: Dental For Employee Only Dental For Employee and Dependents
 Vision For Employee Only Vision For Employee and Dependents

Is your spouse to be covered? Yes No

Dental and/or Vision Coverage Is For (Check Box Below):
 Employee Employee plus Spouse Employee plus Child(ren) Family

Are you or any of your dependents covered for dental insurance under another policy?
 Yes No

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?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Carrier
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

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: _____ 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: _____						

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.

GROUP APPLICATION

Service
Quality
Flexibility ...

COMMITMENT



A Lifetime of Commitment

Companion Life Insurance Company
P.O. Box 100102
Columbia, SC 29202-3102
1-800-753-0404

**APPLICATION FOR GROUP LIFE, AD&D,
SHORT TERM AND LONG TERM DISABILITY INSURANCE, VOLUNTARY STD AND LTD**

EMPLOYER INFORMATION

1. FULL LEGAL NAME OF EMPLOYER (as it should appear in policy) _____ Telephone Number (_____) _____
Area Code
2. EMPLOYER'S FEDERAL TAX ID NUMBER _____ Full Years in Business: _____
 Type of Business: _____ Email Address: _____
i.e.: Partnership, Sole Proprietorship, Corporation, etc.
3. ADDRESS Street _____ Post Office Box _____ ZIP _____
 City _____ County _____ State _____ ZIP _____
4. ADMINISTRATIVE CORRESPONDENCE with the applicant should be addressed to:
 Name _____ Title _____
5. NATURE OF BUSINESS _____
6. REQUESTED EFFECTIVE DATE (12:01 a.m.): _____, 20 _____
7. PREMIUMS ARE TO BE PAID MONTHLY.
8. Are there subsidiary or affiliate businesses covered under this plan? Yes No
 If YES, please state name and nature of each subsidiary or affiliate: _____

 Are separate billings required? Yes No If YES, please provide billing instructions: _____

9. Type of Administration: Home Office administered Group Administered MGU/TPA/GBA Administered
(minimum 250 lives)
10. Will the requested insurance replace existing insurance? Yes No If YES, give coverage, name of existing carrier, and proposed termination date: _____

EMPLOYEE ELIGIBILITY

11. The normal work week for full-time employees is _____ hours.
 Eligibility: All regular full-time employees working a minimum of _____ hours per week.
 (The minimum work week for full-time employees to be eligible for benefits is 30 hours. Employees working fewer than 30 hours per week may be acceptable for Life and STD. Contact Companion Life for approval. LTD requires a minimum of 30 hours per week.)
12. The employee waiting period for participation is:
 None (effective on next billing date).
 After _____ days of continuous employment (30, 60, etc.).
 After _____ months of continuous employment (1, 2, etc.).
13. Current eligible employees are to be covered immediately.
14. Employees hired after the plan effective date are to be covered:
 First of the month following completion of the waiting period.
 Fifteenth of the month following completion of the waiting period.
15. Number of Eligible Employees: _____
16. Number of Enrolled Employees: _____
17. SCHEDULE OF BENEFITS (If space provided is inadequate, please attach additional page.)

CLASS DEFINITIONS (Describe Below)	BASIC LIFE /AD&D	SHORT TERM DISABILITY	LONG TERM DISABILITY	VOLUNTARY STD	VOLUNTARY LTD
Percent of Premium Paid by Employer	%	%	%	%	%

SPECIFICATIONS FOR INSURANCE

18. Are there any ineligible classes or divisions? Yes No If YES, please describe: _____

19. Are any eligible employees disabled at this time? Yes No If YES, please describe: _____

20. Is a Section 125 Plan in effect? Yes No

If yes, please indicate which Companion Life Benefits will be subject to the Section 125 Plan and note the employer's and employee's contributions.

Life & AD&D STD LTD Dental Voluntary Life Voluntary STD Voluntary LTD Voluntary Dental
 ER _____% ER _____% ER _____% ER _____% ER _____% ER _____% ER _____% ER _____%
 EE _____% EE _____% EE _____% EE _____% EE _____% EE _____% EE _____% EE _____%

21. BASIC LIFE AND AD&D BENEFITS reduce as follows (select one):

- 35% at age 65, 50% at age 70, and then 75% at age 75. Benefits terminate when employee is no longer actively at work.
- 35% at age 65, 50% at age 70. Benefits terminate when employee is no longer actively at work.
- _____% at age _____ and then _____% at age _____ and then _____% at age _____.
Benefits terminate when employee is no longer actively at work.

22. BASIC LIFE AND AD&D guaranteed issue amount: \$ _____

23. DEPENDENT LIFE BENEFITS Yes No

- A. Spouse Amount: \$ _____ (Cannot exceed the lesser of 50% of employee's Life amount or \$10,000.)
- B. Maximum Child Amount: \$ _____ (Cannot exceed the lesser of 50% of employee's Life amount or \$10,000.)
- C. Coverage for children continues until age _____, or until age _____ if a full-time student.
- D. Percent of Premiums paid by Employer: _____%

24. SHORT TERM DISABILITY (STD) BENEFITS Yes No (Excludes Occupational injury or sickness)

- A. Benefits are payable from _____ day accident and _____ day sickness for maximum of _____ weeks.
- B. For Benefits expressed as a Flat Amount, the Maximum Benefit will be the lesser of the Flat Amount or 70% of weekly earnings.

25. VOLUNTARY STD Yes No Buy-Up Plan Yes (Select benefit plan below. Must match STD Plan #24A above.)

- A. Enrollment minimum of 5 employees
- B. Full Maternity coverage is included
- C. \$10,000 Accidental Death Benefit is included
- D. A 12/12 Pre-existing condition exclusion applies
- E. Voluntary STD coverage excludes Occupational injury or sickness
- F. The coverage is not available if another STD program from Companion Life is in force (except Buy-Up Plan).
- G. Buy-Up Plan: Employer purchases \$100/wk STD Plan for all eligible employees.

H. Employer's Plan Selected: **1st Plan** **2nd Plan (if applicable)** **Buy-Up Plan Option (if selected)**
 (Enter plan number in box.) (Only for employers with 100 or more eligible employees) (Employees may purchase additional Voluntary STD benefit.)

Benefits Begin

Plan Selected	Accident	Sickness	Duration
Plan 1	1st Day	8th Day	13 Weeks
Plan 2	8th Day	8th Day	13 Weeks
Plan 3	15th Day	15th Day	13 Weeks
Plan 4	1st Day	8th Day	26 Weeks
Plan 5	8th Day	8th Day	26 Weeks
Plan 6	15th Day	15th Day	26 Weeks
Plan 7	15th Day	15th Day	52 Weeks
Plan 8	30th Day	30th Day	52 Weeks

26. TRUE GROUP LONG TERM DISABILITY BENEFITS Yes No
- A. Benefits are payable after an Elimination Period of _____ days. B. Benefits are _____ % of Basic Monthly Earnings.
- C. Maximum Monthly Benefit is not to exceed \$ _____ . D. Minimum Monthly Benefit is \$ _____ .
- E. Maximum Benefit period will be: To Age 65 (Reducing Benefit Duration) 5 Years 2 Years
- F. Own Occupation Definition: 2 Year 3 Year 5 Year Extensive (to age 65)
- G. Benefit integration will be as follows: Primary and Family Social Security (standard) Primary Social Security
- H. Optional Policy Features to be included are specified as follows: _____

- I. Pre-Existing Condition Limitation: (10-24 Lives)
- Standard: 12/6/24 not available in CO, FL, MD, MS, MT, PA, SC, WI, WV
- FL & PA: 3/6/12
- Others: 12/12
- (25+ Lives)
- Standard: 3/6/12

27. VOLUNTARY LONG TERM DISABILITY BENEFITS Yes No

Companion Cornerstone Plan

- A. Maximum Benefit period will be: Two Years/Reducing Benefit Duration Five Years/Reducing Benefit Duration, or Age 65/RBD
- B. Elimination Period: 90 days 180 days Other _____
- C. All employees receive coverage equal to _____ % of their earnings to a maximum monthly benefit of \$ _____, limited to a maximum of \$6,000.
- D. Pre-Existing Condition Limitation: (10-24 Lives)
- Standard: 12/6/24 not available in CO, FL, MD, MS, MT, PA, SC, WI, WV
- FL & PA: 3/6/12
- Others: 12/12

28. SPECIAL REQUESTS/INSTRUCTIONS: _____

EMPLOYER'S SIGNATURE

PLEASE READ CAREFULLY

Quotations were based on the proposal data submitted to Companion Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Companion Life's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. Otherwise, insurance becomes effective only when a policy is delivered and accepted in writing. In the interim, liability is limited to a return of the original deposit. Only Companion Life's home office has the authority to guarantee the acceptability of the requested insurance.

Dated at _____ this _____ day of _____, 20 _____

(Signature of Employer)

(Title)

(Witness)

AGENT'S REPORT

29. INITIAL DEPOSIT (Minimum first month's premium is required.): \$ _____
30. Are all the employees to be insured for Disability Income covered by Workers' Compensation? Yes No
If NO, explain: _____
31. Have you explained to the employer that an employee not actively at work on the policy effective date will not be covered until such employee returns to active work full time unless approved in writing by an underwriter or officer of Companion Life?
 Yes No Remarks: _____
32. Is there another group insurance plan(s) which duplicates any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)? Yes No If YES, please describe the benefit amounts and purpose(s) of this plan(s): _____
33. Is Agent or Broker licensed in the State of this group for the types of insurance solicited? Yes No
34. To the best of the Agent's or Broker's knowledge, replacement is is not involved with this transaction.
35. Print name of Agent/Broker _____
36. Signature of Agent/Broker _____ Date _____

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.

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