

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.

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.

**Voluntary Short Term Disability
 Employee Enrollment Form**

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application) _____ Group Number _____

TO BE COMPLETED BY EMPLOYEE

Your Name	Last	First	Middle Initial	Date of Birth
				/ /
Social Security Number		Date Employed Full-Time		Coverage Effective Date
- -				/ /
Occupation				
Annual Earnings		Hours Worked Per Week		Sex
\$				M F
Beneficiary			Relationship	

BENEFIT LEVELS

Select the Benefit Level (A-M) that meets your needs from the chart below and enter the Benefit Level letter in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary Must Be at Least
A	\$150	\$11,700
B	\$200	\$15,600
C	\$250	\$19,500
D	\$300	\$23,400
E	\$350	\$27,300
F	\$400	\$31,200
G	\$450	\$35,100
H	\$500	\$39,000
I	\$550	\$42,900
J	\$600	\$46,800
K	\$650	\$50,700
L	\$700	\$54,600
M	\$750	\$58,500

Benefit Level Selected

Weekly Benefits will Equal the Amount Selected, Not to Exceed 66⅔% of Basic Weekly Earnings

I elect the above benefits which I have selected from all those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the necessary contribution from my wages.

FRAUD WARNING (Not Applicable in AZ, FL, MD, VA or MN): 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 _____	Do Not Write in This Box Unless Instructed To Do So
------------	----------------------	---

If you are refusing coverage, sign below and return this form to your employer.

I acknowledge that I have been offered Voluntary Short Term Disability Insurance by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, if I should apply at a later date. The company shall have the right to decline coverage.

Date: _____ Signature: _____



Companion Life Insurance Company
 Post Office Box 100102
 Columbia, South Carolina 29202-3102
 1-800-753-0404

Voluntary Short Term Disability Employee Enrollment Form Two Option Plan

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group Number
---	--------------

TO BE COMPLETED BY EMPLOYEE

Your Name	Last	First	Middle Initial	Date of Birth
				/ /
Social Security Number		Date Employed Full-Time		Coverage Effective Date
		/ /		/ /
Occupation				
Annual Earnings		Hours Worked Per Week		Sex
\$				M F
Beneficiary			Relationship	

BENEFIT LEVELS

Select the Benefit Level (A-M) that meets your needs from the chart below and enter the Benefit Level letter in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary Must Be at Least
A	\$150	\$11,700
B	\$200	\$15,600
C	\$250	\$19,500
D	\$300	\$23,400
E	\$350	\$27,300
F	\$400	\$31,200
G	\$450	\$35,100
H	\$500	\$39,000
I	\$550	\$42,900
J	\$600	\$46,800
K	\$650	\$50,700
L	\$700	\$54,600
M	\$750	\$58,500

Benefit Level

The Weekly Benefit selected cannot exceed 66⅔% of Basic Weekly Earnings.

Two Option Plan

You may choose one of the plans shown below. Enter the letter shown of the plan of your choice in the box below.

Plan _____

Plan _____

I elect the above benefits which I have selected from all those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the necessary contribution from my wages.

FRAUD WARNING (Not Applicable in AZ, FL, MD, VA or MN): 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
------	----------------

Do Not Write in This Box Unless Instructed To Do So



Companion Life

Companion Life Insurance Company
Post Office Box 100102
Columbia, South Carolina 29202-3102
1-800-753-0404

Voluntary Short Term Disability Employee Enrollment Form

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)

Group Number

TO BE COMPLETED BY EMPLOYEE

Your Name Last	First	Middle Initial	Date of Birth / /
Social Security Number - -	Date Employed Full-Time / /		Coverage Effective Date / /
Occupation			
Annual Earnings \$	Hours Worked Per Week	Sex M F	
Beneficiary		Relationship	

BENEFIT LEVELS

Select the Benefit Level (A-M) that meets your needs from the chart below and enter the Benefit Level letter in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary Must Be at Least
A	\$ 50	\$11,700
B	\$100	\$15,600
C	\$150	\$19,500
D	\$200	\$23,400
E	\$250	\$27,300
F	\$300	\$31,200
G	\$350	\$35,100
H	\$400	\$39,000
I	\$450	\$42,900
J	\$500	\$46,800
K	\$550	\$50,700
L	\$600	\$54,600
M	\$650	\$58,500

Employee Buy-Up Program

Your Employer Has Agreed to Provide a Disability Benefit for You in the Amount of \$100 Per Week. To Further Supplement Your Income, You May Purchase an Additional Benefit Through Payroll Deduction.

Benefit Level Selected

The Weekly Benefit Selected, When Added to the Benefit Provided By Your Employer, Cannot Exceed 66⅔% of Basic Weekly Earnings.

I elect the above benefits which I have selected from all those for which I am eligible. If any contribution from me is necessary to pay part or all of the cost of the insurance, I authorize my employer to deduct the necessary contribution from my wages.

FRAUD WARNING (Not Applicable in AZ, FL, MD, VA or MN): 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 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: _____