GROUP INSURANCE ENROLLMENT FORM AND CHANGE REQUEST

Companion Life

Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

☐ 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

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group No. (10 digit #)	DEPT/DIV (3 digit #)	CLASS

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: ☐ Female ☐ Male

☐ Weekly ☐ Monthly ☐ Annually
Earnings $ _____ *
**Do not include overtime or bonuses*

Marital Status	Occupation	Your Home Address
☐ Single ☐ Married		Street / Apt/Suite No. / City / State / ZIP Code

COMPLETE FOR LIFE AND/OR DISABILITY

COVERAGE REQUESTED ☐ Basic Life ☐ AD&D ☐ Dependent Life ☐ Short Term Disability ☐ Long Term Disability
☐ Voluntary Life ☐ Voluntary Long Term Disability

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

Spouse Name: *(Voluntary Life Only)* Last / First / M.I.	Birthdate (M/D/Y)	Social Security Number

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage.)*
Last / First / M.I. / 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 / M.I.)	**Date of Birth** M / D / Y	**Gender** M or F	**Do any of your dependents have any other dental coverage?**	**If Yes, Name of Carrier**
				☐ Yes ☐ No	
CHILDREN	1)			☐ Yes ☐ No	
	2)			☐ Yes ☐ No	
	3)			☐ Yes ☐ No	
	4)			☐ Yes ☐ 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 ☐ Short Term Disability ☐ Long Term Disability ☐ Dental ☐ Vision
☐ Voluntary Life ☐ Voluntary Long Term Disability ☐ 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.