



COMPANION LIFE INSURANCE COMPANY
PO Box 100102, Columbia, SC 29202-3102

COMPANION LIFE MASTER APPLICATION

New Group Application Coverage Change

Effective Date ___ / ___ / _____

Group Number _____

EMPLOYER INFORMATION

1. Company Name _____ 2. Contact _____
 3. Address _____ City _____ State _____ Zip _____
 4. Telephone (____) ____ - _____ Fax (____) ____ - _____ E-mail _____
 5. Tax ID Number _____ - _____ 6. SIC/Nature of Business _____

ELIGIBILITY All Groups

7. Normal work week for full-time employees is _____ hours. (Minimum of 30 hours per week required.)
 8. Waiting period for initial enrollment: Immediate 30 days 60 days 90 days 180 days
 Waiting period for future employees: 30 days 60 days 90 days 180 days
 Following completion of the probationary period, coverage will be effective the 1st or 15th of the month.
 9. Number of Eligible Employees: _____ 10. Number of Enrolled Employees: _____
 11. Are there any classes of ineligible employees: Yes No Explain _____
 12. Are any persons to be covered retired, currently hospitalized, disabled, or on extension of benefits?
 Yes No If yes, give details _____
 13. Are all employees to be insured covered by Workers Compensation? Yes No
 14. Current Life Insurance Carrier _____ Will this insurance replace existing insurance? Yes No
 15. Percentage of premium paid by employer: Life & AD&D _____% STD _____% LTD _____% Dep. Life _____%

COVERAGE INFORMATION Groups with 2 – 9 Lives Only

16. **Life and AD&D**
 Flat Amount Plan: \$10,000 \$15,000 \$20,000 \$30,000 \$40,000 \$50,000
 Class Plan: Class 1. _____ Amount \$ _____
 Class 2. _____ Amount \$ _____
 Class 3. _____ Amount \$ _____
 17. **Dependent Life** No Yes (Spouse \$2,000; Children \$1,000; 14 days - 6 months \$200)
 18. **Short Term Disability** No Yes
 Flat Amount Plan: \$200/week Benefit Period: 13 weeks 26 weeks
 Percent of Earnings: 60% to a maximum of \$600/week Benefits Begin: 1st day Accident; 8th day illness

Participation Agreement (administered and underwritten by Companion Life Insurance Company)

The Participant does hereby apply for Group Insurance Benefits as set forth in the above application.
 Name of Trust: Joint Employer Group Insurance Trust. It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does he or she 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 Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy. **The undersigned employer agrees that coverage shall not commence until this application has been approved by Companion Life Insurance Company and notice of approval has been transmitted to us.** As named employer, I understand that I should not cancel any existing coverage until notified that this application has been accepted by Companion Life.

Signature of Applicant/Title _____ Date ___ / ___ / _____

Signature of Agent Broker _____ Agent Code _____ - _____ Date ___ / ___ / _____

LIFE SPECIFICATIONS *Groups of 10 and Above Only*

19. Life Insurance and Accidental Death & Dismemberment

Class Definitions (describe below)	Basic Life/AD&D	Dependent Life Insurance
Class 1. _____	\$ _____	_____ Yes _____ No
Class 2. _____	\$ _____	(\$5000)
Class 3. _____	\$ _____	
Class 4. _____	\$ _____	

- Notes: A. Basic Life & AD&D Benefits reduce 35% at age 65, and then to 50% at age 70. Benefits terminate at retirement.
 B. Waiver of Premium is provided as a continuation of Life Benefits in the event of total disability
 C. An Accelerated Death Benefit is included.

DISABILITY SPECIFICATIONS *Groups of 13 and Above Only*

20. Short Term Disability

Class Definitions (describe below)	Benefits	Accident (Days)	Illness (Days)	Duration (Weeks)
Class 1. _____	_____	_____	_____	_____
Class 2. _____	_____	_____	_____	_____
Class 3. _____	_____	_____	_____	_____
Class 4. _____	_____	_____	_____	_____

21. Long Term Disability (MINIMUM OF 6 EMPLOYEES TO BE ELIGIBLE)

Class Definitions (describe below)	Benefits	Maximum Benefit (monthly)	Minimum Benefit (monthly)	Elimination Period (days)	Maximum Duration (years)
Class 1. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 2. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 3. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 4. _____	_____ %	\$ _____	\$ _____	_____	_____

22. Benefit Integration will be as follows:

- Primary & Family Social Security (standard)
- Primary Social Security
- Primary & Family Social Security with 70% all Sources

23. Pre-existing Conditions Exclusion:

- 12/12 (Groups 6 - 24)
- 3/6/12 (Groups 25 and greater)

24. Optional policy features to be included are: _____

APPLICANT'S SIGNATURE

Quotations were based upon 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. Only Companion Life's Home Office has the authority to guarantee the acceptability of the requested insurance.

Signature of Applicant/Title _____ Date ____ / ____ / ____

Signature of Agent _____ Agent Code _____ - _____ Date ____ / ____ / ____