GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life

Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202-3102
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 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: ☐ Female ☐ Male

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

Marital Status: ☐ Single ☐ Married

Occupation

Your Home Address — 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

COMPLETE FOR VOLUNTARY LIFE

Amount Selected:
EMPLOYEE: Voluntary Life $ _____ **SPOUSE:** Voluntary Life $ _____ **CHILD:** Voluntary Life $ _____

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 dependent coverage) (Applies to Life, Disability and Critical Illness)*
Last / First / M.I. / Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION AND/OR CRITICAL ILLNESS

Coverage Requested:
☐ Dental - Employee Only ☐ Dental - Employee & Dependents
☐ Vision - Employee Only ☐ Vision - Employee & Dependents
☐ Critical Illness - Employee Only ☐ Critical Illness - Employee & 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 ☐ Critical Illness ☐ Voluntary Life ☐ Voluntary Long Term Disability ☐ Voluntary Dental

Date	Your Signature
	X

See Pages Two and Three for Companion Life Form 95734 for Fraud Notices

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.