

COMPANION LIFE INSURANCE COMPANY

GROUP INSURANCE ENROLLMENT

Administered by:

Companion Life Insurance Company
 800 Main Street
 P.O. Box 1535
 Dubuque, IA 52004-1535
 Telephone Number: (877) 676-5789

Underwritten by:



Companion Life

P.O. Box 100102 | Columbia, S.C.
 29202-3102
 800-753-0404 (Phone)

Companion Life Insurance Company	Companion Use ONLY
<input type="checkbox"/> New Employee <input type="checkbox"/> Add/Increase <input type="checkbox"/> Coverage <input type="checkbox"/> Change Address <input type="checkbox"/> Change Beneficiary <input type="checkbox"/> COBRA <input type="checkbox"/> Change Dependent Coverage <input type="checkbox"/> Change Class or Status <input type="checkbox"/> Terminate Coverage	Approved: <input type="checkbox"/> Declined: <input type="checkbox"/> Date: _____ By: _____

POLICYHOLDER INFORMATION – to be completed by the Employer or Group Administrator
Name of Employer (Use Name from Group Billing Notice or Master Application) _____ Group. No (10 Digit #) _____ DEPT/DIV (3 Digit #) _____ CLASS _____

PROPOSED INSURED INFORMATION (PLEASE PRINT) – to be completed by the Employee/Enrollee			
Last Name (Include Jr., Sr., etc.)	First Name	M.I.	
Street Address	Apt Number	City	State/Zip
Social Security Number	Home Telephone		Work Telephone
Male <input type="checkbox"/> Female <input type="checkbox"/> Date of Birth(MM-DD-YY) / /	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually Earnings \$ _____ *Do not include overtime or bonuses		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Occupation	Hours Worked Per Week	

PLAN AND COVERAGE SELECTION
<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + children <input type="checkbox"/> Family

COMPLETE FOR LIFE AND/OR DISABILITY

COVERAGE REQUESTED <input type="checkbox"/> Basic Life <input type="checkbox"/> AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> Voluntary Life
(Amount Selected for Voluntary Life) EMPLOYEE : \$ <input style="width: 100px;" type="text"/> SPOUSE: \$ <input style="width: 100px;" type="text"/> CHILD: \$ <input style="width: 100px;" type="text"/>

Spouse Name: Last/First/M.I. (Voluntary Life Only)	Birthdate (M/D/Y)	Social Security Number
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Beneficiary for Employee Coverage/Relationship: <i>(Employee is beneficiary for spouse coverage.)</i>			
Last	First	M.I.	Relationship to Insured

DEPENDENT INFORMATION (please attach additional pages as needed)			Do any of your Dependents have any other coverage?
Spouse Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY) / /	<input type="checkbox"/> Yes If yes, Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY) / /	<input type="checkbox"/> Yes If yes, Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY) / /	<input type="checkbox"/> Yes If yes, Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY) / /	<input type="checkbox"/> Yes If yes, Name of Carrier <input type="checkbox"/> No
Child Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY) / /	<input type="checkbox"/> Yes If yes, Name of Carrier <input type="checkbox"/> No

DEPENDENTS: Eligible Dependents are determined by your employer's eligibility terms.

AUTHORIZATION

I agree do not agree to have the certificate documents delivered to the Policyholder electronically.

I elect the coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages.

Any person who knowingly presents a false or fraudulent statement in an application for insurance may be guilty of a criminal offense and subject penalties under state law.

Proposed Insured's Signature: _____ **Date:** _____

REFUSAL/WAIVER – Complete ONLY if you are declining coverage for yourself or any Dependent.

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.

Proposed Insured's Signature: _____ **Date:** _____

Coverage Refused (Check All That Apply)

Basic Life AD&D Dependent Life Voluntary Life



[P.O. Box 100102 | Columbia, S.C. 29202-3102
800-753-0404 (Phone) | 800-836-5433]

**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.