GROUP MASTER
EMPLOYER APPLICATION

☐ SHORT-TERM DISABILITY ☐ VOLUNTARY SHORT-TERM DISABILITY

☐ LONG-TERM DISABILITY ☐ VOLUNTARY LONG-TERM DISABILITY

☐ TERM LIFE and AD&D ☐ VOLUNTARY TERM LIFE and AD&D

☐ DEPENDENT TERM LIFE ☐ VOLUNTARY DEPENDENT TERM LIFE and AD&D

☐ DENTAL

☐ VISION

☐ GAP ☐ CRITICAL ILLNESS ☐ DEPENDENT CRITICAL ILLNESS ☐ ACCIDENT

☐ HOSPITAL INDEMNITY

Underwritten by: Companion Life Insurance Company

P.O. Box 100102

Columbia, South Carolina 29202

(803) 735-1251

Administered by: Companion Life Insurance Company

800 Main Street

P.O Box 1535

Dubuque, IA 52004-1535

Telephone Number (877) 676-5789

Fax: (563) 577-3351

If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Employer.

Please Print or Type

POLICYHOLDER INFORMATION

1. Full Legal Name of Employer (As it should appear in the Policy)

Telephone Number

( )

2. Employer's Federal Tax ID Number

Full Years in Business

3. Street Address City State ZIP

P.O. Box City State ZIP

4. Administrative Correspondence with the Employer should be addressed to:

Name Title Email Address

5. Nature of Business

6. Requested Effective Date

7. 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.

8. Type of Administration: ☐ Home-Office Administered ☐ Self-Administered ☐ Third Party Administered

TPA Name _____

ELIGIBILITY NFORMATION

9. An eligible Active Employee is Full Time, works _____ hours or more per week and is a legal resident or citizen of the U.S.

COVERAGE INFORMATION

SHORT-TERM DISABILITY SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
   - ☐ Immediately on the requested effective date.
   - ☐ After_____days of continuous employment.
   - ☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
   - ☐ Immediately on the date of hire.
   - ☐ After_____days of continuous employment.
   - ☐ 1st of the month following____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

5. Percent of Enrollee Premium Paid by Employer: _____%
   Additional notes:

6. Is a Section 125 Plan in effect? ☐ Yes ☐ No

   If YES, please indicate if this benefit will be subject to the Section 125 Plan and note the Employer's and Employee's contributions.
   - ☐ STD
     Employer_____%
     Employee_____%
   - ☐ This benefit is not part of the Section 125 plan.

7. SPECIAL REQUESTS/INSTRUCTIONS

VOLUNTARY SHORT-TERM DISABILITY SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
   - ☐ Immediately on the requested effective date.
   - ☐ After_____days of continuous employment.
   - ☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
   - ☐ Immediately on the date of hire.
   - ☐ After_____days of continuous employment.
   - ☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

5. Percent of Enrollee Premium Paid by Employer: _____%
Additional notes:

_____

6. Is a Section 125 Plan in effect? ☐ Yes ☐ No

If YES, please indicate if this benefit will be subject to the Section 125 Plan and note the Employer's and Employee's contributions.

☐ Voluntary STD
Employer_____%
Employee_____%

☐ This benefit is not part of the Section 125 plan.

7. SPECIAL REQUESTS/INSTRUCTIONS

LONG-TERM DISABILITY SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
☐ Immediately on the requested effective date.
☐ After_____days of continuous employment.
☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
☐ Immediately on the date of hire.
☐ After_____days of continuous employment.
☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Enrollee Premium Paid by Employer: _____%
Additional notes:

_____

6. Is a Section 125 Plan in effect? ☐ Yes ☐ No

If YES, please indicate if this benefit will be subject to the Section 125 Plan and note the Employer's and Employee's contributions.

☐ LTD
Employer_____%
Employee_____%

☐ This benefit is not part of the Section 125 plan.

7. SPECIAL REQUESTS/INSTRUCTIONS

VOLUNTARY LONG-TERM DISABILITY SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
- ☐ Immediately on the requested effective date.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
- ☐ Immediately on the date of hire.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Enrollee Premium Paid by Employer: _____%
Additional notes:

_____

6. Is a Section 125 Plan in effect? ☐ Yes ☐ No

If YES, please indicate if this benefit will be subject to the Section 125 Plan and note the Employer's and Employee's contributions.

- ☐ Voluntary LTD

  Employer_____%
  Employee_____%
- ☐ This benefit is not part of the Section 125 plan.

7. SPECIAL REQUESTS/INSTRUCTIONS

TERM LIFE and DEPENDENT TERM LIFE and AD&D SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Plan Selection
☐ Employee ☐ Employee + Dependents

2. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

3. Current eligible enrollees are to be covered:
- ☐ Immediately on the requested effective date.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following_____days of continuous employment.

4. Employees hired after the plan effective date are to be covered:
- ☐ Immediately on the date of hire.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following_____days of continuous employment.

5. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

6. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
Additional notes:

_____

7. Is a Section 125 Plan in effect? ☐ Yes ☐ No

If YES, please indicate if these benefits will be subject to the Section 125 Plan and note the Employer's and Employee's contributions.

☐ Term Life
Employer_____%
Employee_____%

☐ AD&D
Employer_____%
Employee_____%

☐ The benefits are not part of the Section 125 plan.

8. SPECIAL REQUESTS/INSTRUCTIONS

VOLUNTARY TERM LIFE and VOLUNTARY DEPENDENT TERM LIFE and AD&D SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE

Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
☐ Immediately on the requested effective date.
☐ After_____days of continuous employment.
☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
☐ Immediately on the date of hire.
☐ After_____days of continuous employment.
☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
Additional notes:

_____

6. Is a Section 125 Plan in effect? ☐ Yes ☐ No

If YES, please indicate if these benefits will be subject to the Section 125 Plan and note the Employer's and Employee's contributions.

☐ Voluntary Term Life
Employer_____%
Employee_____%

☐ Voluntary AD&D
Employer_____%
Employee_____%

☐ The benefits are not part of the Section 125 plan.

7. SPECIAL REQUESTS/INSTRUCTIONS

DENTAL SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
   ☐ Immediately on the requested effective date.
   ☐ After_____days of continuous employment.
   ☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
   ☐ Immediately on the date of hire.
   ☐ After_____days of continuous employment.
   ☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
   Additional notes:

_____

6. Is prior insurance credit (takeover benefits) requested? ☐ Yes ☐ No

7. The following documentation is required when prior insurance credit is requested. Your prior dental plan must have been in effect continuously for at least 12 months prior to the effective date.
   - Evidence that the prior carrier's coverage has been in force for at least 12 months.
   - A copy of the most recent bill which includes a listing of all covered enrollees.
   - A copy of the prior dental plan.

8. SPECIAL REQUESTS/INSTRUCTIONS

VISION SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
   ☐ Immediately on the requested effective date.
   ☐ After_____days of continuous employment.
   ☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
   ☐ Immediately on the date of hire.
   ☐ After_____days of continuous employment.
   ☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
Additional notes:

_____

6. SPECIAL REQUESTS/INSTRUCTIONS

GAP SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
- ☐ Immediately on the requested effective date.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following _____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
- ☐ Immediately on the date of hire.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following _____ days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
Additional notes:

_____

6. SPECIAL REQUESTS/INSTRUCTIONS

The Group Limited Benefit Medical Supplement Policy provides limited benefits. Review your Policy carefully. This coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). Please check the Policy to understand what the Policy covers and does not cover (including exclusions and treatment limitations on health benefits outside the scope of coverage). If coverage expires or eligibility for coverage under the policy is lost, You may have to wait until an open enrollment period to obtain other health insurance coverage.

CRITICAL ILLNESS and DEPENDENT CRITICAL ILLNESS SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
- ☐ Immediately on the requested effective date.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
- ☐ Immediately on the date of hire.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following _____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
Additional notes:

_____

6. SPECIAL REQUESTS/INSTRUCTIONS

The Group Critical Illness Policy provides limited benefits. Review your Policy carefully. This coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). Please check the Policy to understand what the Policy covers and does not cover (including exclusions and treatment limitations on health benefits outside the scope of coverage). If coverage expires or eligibility for coverage under the policy is lost, You may have to wait until an open enrollment period to obtain other health insurance coverage.

HOSPITAL INDEMNITY SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
- ☐ Immediately on the requested effective date.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
- ☐ Immediately on the date of hire.
- ☐ After_____days of continuous employment.
- ☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
Additional notes:

_____

6. SPECIAL REQUESTS/INSTRUCTIONS

NO BENEFITS WILL BE PAYABLE FOR EXPENSES INCURRED AS A RESULT OF A PRE-EXISTING CONDITION UNTIL THE INSURED INDIVIDUAL HAS BEEN INSURED UNDER THE POLICY FOR 6 MONTHS FROM THE EFFECTIVE DATE

The Group Hospital Indemnity Policy is a supplemental policy that is not intended to provide the minimum essential coverage required by the Affordable Care Act (ACA). Unless you have another plan (such as major medical coverage) that provides minimum essential coverage in accordance with the ACA, you may be subject to a federal tax penalty. Also, the benefits provided by this Policy cannot be coordinated with the benefits provided by other coverage. please review the benefits provided by this Policy carefully to avoid a duplication of coverage.

ACCIDENT SEE ATTACHED PROPOSAL FOR SPECIFICATION FOR INSURANCE Clear this section

1. Will the requested insurance replace existing insurance? If YES, list current policy number (if available), coverage, name of existing carrier and proposed termination date: ☐ Yes ☐ No

Current Policy Number: Coverage:
Name of Existing Carrier: Proposed Termination Date:

2. Current eligible enrollees are to be covered:
☐ Immediately on the requested effective date.
☐ After_____days of continuous employment.
☐ 1st of the month following_____days of continuous employment.

3. Employees hired after the plan effective date are to be covered:
☐ Immediately on the date of hire.
☐ After_____days of continuous employment.
☐ 1st of the month following_____days of continuous employment.

4. Are any Employees excluded from coverage? ☐ Yes ☐ No If YES, please describe

_____

5. Percent of Premium Paid by Employer: Enrollee Only_____% Dependents_____%
Additional notes:

_____

6. SPECIAL REQUESTS/INSTRUCTIONS

The Group Accident Policy provides limited benefits. Review your Policy carefully. This coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). Please check the Policy to understand what the Policy covers and does not cover (including exclusions and treatment limitations on health benefits outside the scope of coverage). If coverage expires or eligibility for coverage under the policy is lost, You may have to wait until an open enrollment period to obtain other health insurance coverage.

EMPLOYER'S SIGNATURE

DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED IN WRITING BY THE INSURANCE COMPANY OF ACCEPTANCE OF THIS APPLICATION

The undersigned, who is an officer of Employer and authorized to enter into this contract, represents the following to be true:

1) all answers contained herein are true and complete;
2) the Company may institute inspection reports with regard to questions answered herein;
3) the Company may decline acceptance of the Application or where permitted by law, any person for whom coverage is requested;
4) no coverage will become effective under this plan of insurance until written approval is received from the Company; and
5) that the Company may terminate the policy(ies) by giving advance written notice as required in the Policy.

FRAUD NOTICE

General Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN R.S.A. 638:20.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Vermont: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PLEASE READ CAREFULLY

The Policy forms will be delivered to the group electronically unless you request in writing to receive a paper copy. The Certificate package for distribution to all insureds will be delivered to you electronically unless you request in writing to receive a paper copy for distribution.

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 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, if any. Only Companion Life's home office has the authority to guarantee the acceptability of the requested insurance.

Dated at_____this_____day of_____, 20_____

City/State

_____ _____

Signature of Employer Title

AGENT/BROKER'S REPORT Clear this section

10. INITIAL DEPOSIT $_____

11. Are all the Employees to be insured for Disability Income covered by Workers' Compensation? ☐ Yes ☐ No ☐ N/A

If NO, explain _____

12. 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 _____

13. 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).

_____

14. Is Agent or Broker licensed in the state of this group for the types of insurance solicited? ☐ Yes ☐ No

15. To the best of the Agent's or Broker's knowledge, replacement

☐ is involved with this transaction.

☐ is not involved with this transaction.

16. Agent/Broker Name (Please Print) _____

Agent/Broker Telephone Number ___ (_____) _____

Agent/Broker Email Address _____

17. Signature of Agent/Broker_____Date _____

www.CompanionLife.com

PRODUCTS NOT APPROVED IN ALL STATES