GROUP MASTER EMPLOYEE ENROLLMENT FORM

Administered by:
Companion Life Insurance Company
800 Main Street
P. O. Box 1535
Dubuque, IA 52004-1535
Telephone Number: (877) 676-5789
Fax: (877) 557-3350

Underwritten by: Companion Life Insurance Company

Companion Life
P.O. Box 100102 | Columbia, SC 29202-3102
800-753-0404 (Phone) | 800-836-5433 (Fax)

Companion Life Insurance Company			Companion Life Use ONLY
☐ New Employee ☐ Add/Increase Coverage	☐ Change Address ☐ Change Dependent Coverage ☐ Change Class or Status ☐ Terminate Coverage	☐ Change Beneficiary ☐ COBRA	Approved: ☐ Declined: ☐ Date:_____ By: _____

POLICYHOLDER INFORMATION – to be completed by the Policyholder or Group Administrator

Employer Name:_____ DBA:_____

Group Number:_____ Dept/Div Number:_____ Class:_____

ENROLLEE 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		Primary Phone Number Work Phone Number		Email Address
Male ☐ Female ☐	Date of Birth (MM-DD-YY)	☐ Weekly ☐ Monthly ☐ Annually Earnings $_____ Do not include overtime or bonuses		
Marital Status ☐ Married ☐ Single	Occupation	Hours Worked Per Week_____		Hire Date: Coverage Effective Date:

COVERAGE SELECTION

☐ Short-Term Disability
☐ Voluntary Short-Term Disability
☐ Long-Term Disability
☐ Voluntary Long-Term Disability
☐ Term Life and AD&D
☐ Dependent Term Life
☐ Voluntary Term Life
☐ Voluntary Dependent Term Life
☐ Dental
☐ Vision
☐ GAP
☐ Critical Illness ☐ Dependent Critical Illness
☐ Hospital Indemnity ☐ Accident

DEPENDENT INFORMATION			**Do any of your Dependents have any other coverage?** *(Dental Only)*
Spouse Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No

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

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

VOLUNTARY SHORT-TERM DISABILITY

1. **Primary Beneficiary for Employee Coverage/Relationship:**

Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship:

Last First M.I. Relationship to Insured

2. **BENEFITS**

Benefit Levels – Standard Option:

Select the Benefit Level (A-W) that meets your needs from the chart below and enter the Benefit Level letter in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary must be at least	Benefit Level	Weekly Benefit	Your Annual Salary must be at least
A	$150	$11,700	T	$1100	$85,800
B	$200	$15,600	U	$1150	$89,700
C	$250	$19,500	V	$1200	$93,600
D	$300	$23,400	W	$1250	$97,500
E	$350	$27,300			
F	$400	$31,200			
G	$450	$35,100			
H	$500	$39,000			
I	$550	$42,900			
J	$600	$46,800			
K	$650	$50,700			
L	$700	$54,600			
M	$750	$58,500			
N	$800	$62,400			
O	$850	$66,300			
P	$900	$70,200			
Q	$950	$74,100			
R	$1000	$78,000			
S	$1050	$81,900			

Benefit Level Selected

The Weekly Benefit selected cannot exceed 66 2/3% Of Basic Weekly Earnings.

LONG-TERM DISABILITY

1. **Primary Beneficiary for Employee Coverage/Relationship:**

Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship:

Last First M.I. Relationship to Insured

VOLUNTARY LONG-TERM DISABILITY

1. **Primary Beneficiary for Employee Coverage/Relationship:**

Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship:

Last First M.I. Relationship to Insured

TERM LIFE and DEPENDENT TERM LIFE

1. **Primary Beneficiary for Employee Coverage/Relationship:** *(Employee is beneficiary for spouse coverage)*

Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage)*

Last First M.I. Relationship to Insured

VOLUNTARY TERM LIFE and VOLUNTARY DEPENDENT TERM LIFE

1.**PLAN SELECTION**

☐ Employee ☐ Employee + Spouse ☐ Employee + children ☐ Family

If Voluntary AD&D has been selected by the Employer, your Voluntary AD&D benefit will be equal to the amount of Voluntary Term Life coverage you select.

2. **COVERAGE REQUESTED** ☐ Voluntary Term Life ☐ Voluntary Dependent Term Life

(Amount Selected for Voluntary Life)

EMPLOYEE: $ _____ **SPOUSE**: $ _____ **CHILD:** $ _____

Spouse Name: Last/First/M.I. Birthdate (M/D/Y)

3. **Primary Beneficiary for Employee Coverage/Relationship:** *(Employee is beneficiary for spouse coverage)*

Last First M.I. Relationship to Insured

Secondary Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage)*

Last First M.I. Relationship to Insured

DENTAL

1. **PLAN SELECTION**

☒ Employee ☒ Employee + Spouse
☒ Employee + children ☒ Family

VISION

1. **PLAN SELECTION**

☐ Employee ☐ Employee + Spouse
☐ Employee + children ☐ Family

GAP

1. **PLAN SELECTION**

☐ Employee ☐ Employee + Spouse ☐ Employee + children ☐ Family

THE 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 THE POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY YOUR CERTIFICATE CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

I understand and acknowledge that no coverage will take effect for myself or dependents, if any, who is not also covered by a Health Benefit Plan, in force at the time of my Requested Effective Date for this coverage.

☐ I confirm that I and my dependents, if any, are currently covered under a Health Benefit Plan or have enrolled for a Health Benefit Plan.

CRITICAL ILLNESS and DEPENDENT CRITICAL ILLNESS

1. **PLAN SELECTION**

☒ Employee
☒ Employee + Dependents

THE 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

1. **PLAN SELECTION**

☐ Employee
☐ Employee + Spouse
☐ Employee + children
☐ Family

THE 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.

The undersigned understands that no benefits will be payable for loss incurred as a result of a pre-existing condition (as defined in the policy) until coverage has been in effect under this plan for 6 consecutive months.

ACCIDENT

1. **PLAN SELECTION**

☐ Employee

☐ Employee + Family

THE 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.

AUTHORIZATION FOR DEDUCTION

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. I affirm, to the best of my knowledge and belief, that all information given by me on this form is true and complete. I have read or had read to me any Fraud notice below applicable to my state of issue of this enrollment form.

Enrollee's Signature:_____ **Date:**_____

REFUSAL/WAIVER – Complete ONLY if you are declining one or more offered coverages.

I have been offered insurance coverage as permitted by my Employer and decline to participate in the coverages not selected on the first page. I acknowledge that any coverage offered through my Employer not expressly selected on this application will be considered refused. I understand that in the event I desire such coverage at a later date, I may be required to furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, and the Company shall have the right to refuse any request.

Enrollee's Signature:_____ **Date:**_____

NOTICE TO ENROLLEE – DETACH AND GIVE TO ENROLLEE

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.

Please See Pages 5 - 7 for Companion Life Insurance Company Fraud Notices

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.