Companion Life

EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

800-753-0404

EMPLOYER INFORMATION

Firm Name ______

Address ______ City ______ State ______ Zip ______

Telephone ( ) ______ Firm Contact ______ Title ______
(person to contact concerning coverages)

Type of Business ______ (i.e., sole proprietorship, partnership, corporation, etc).

Full-time Employees in Firm: ______ # Full-time Employees Enrolled: ______

Effective Date Requested: ______ SIC Code or Nature of Business: ______
(The firm's effective date will be the first or the 15th of the month following written acceptance by Companion Life Insurance Company.)

How many years in this business? ______ How many years in this location? ______

Tax I.D. Number ______ Will this insurance replace existing insurance? ______

Name of existing carrier ______ Which coverages are being replaced? ☐ Life and AD&D ☐ STD

☐ Life and AD&D

☐ Flat Amount Plan ($10,000 to $100,000)
- ☐ $10,000 ☐ $15,000 ☐ $25,000
- ☐ $50,000 ☐ $75,000 ☐ $100,000
- ☐ ______ Other (in $5,000 increments)

☐ Class Plan

Class	Description	Life and AD&D Amount
1	______	$ ______
2	______	$ ______
3	______	$ ______

Percent of premium paid by employer ______%
(A minimum of 25% is required.)

☐ Dependent Life ☐ Yes ☐ No

Spouse: $10,000
Children: $5,000
Children: 14 days - 6 months: $200

Waiting Period

Initial Enrollment
☐ One month ☐ Other ______

Future Employees
☐ One month ☐ Other ______

☐ STD

Percent of Earnings

60% to a maximum benefit of (select one):

☐ $1,000/week ☐ $______/week

Benefit Period ☐ 13 weeks ☐ 26 weeks

Benefits Begin: First Day (Accident) Eighth Day (Illness)

Percent of premium paid by employer ______%
(A minimum of 25% is required.)

Life and AD&D Total Monthly Premium		Dependent Life Total Monthly Premium		STD Total Monthly Premium				Total Monthly Premium
$ ______	+	$ ______	+	$ ______	+	$10.00 per month Administration Fee	=	$ ______

Are any of the persons to be covered retired, currently hospitalized, disabled or on any extension of benefits? ☐ Yes ☐ No (If yes, give details.)

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): 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.

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 "Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

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 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 Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666. 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 ______ Date ______

Printed Name ______

FOR HOME OFFICE USE

Accepted by Administrator Effective: ______

By: ______

Title ______ Date ______