



COMPANION LIFE INSURANCE COMPANY  
PO Box 100102, Columbia, SC 29202-3102

**COMPANION LIFE MASTER APPLICATION**

New Group Application  Coverage Change

Effective Date \_\_\_ / \_\_\_ / \_\_\_\_\_

Group Number \_\_\_\_\_

**EMPLOYER INFORMATION**

1. Company Name \_\_\_\_\_ 2. Contact \_\_\_\_\_  
 3. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 4. Telephone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_  
 5. Tax ID Number \_\_\_\_\_ - \_\_\_\_\_ 6. SIC/Nature of Business \_\_\_\_\_

**ELIGIBILITY All Groups**

7. Normal work week for full-time employees is \_\_\_\_\_ hours. (Minimum of 30 hours per week required.)  
 8. Waiting period for initial enrollment:  Immediate  30 days  60 days  90 days  180 days  
 Waiting period for future employees:  30 days  60 days  90 days  180 days  
 Following completion of the probationary period, coverage will be effective the 1<sup>st</sup> or 15<sup>th</sup> of the month.  
 9. Number of Eligible Employees: \_\_\_\_\_ 10. Number of Enrolled Employees: \_\_\_\_\_  
 11. Are there any classes of ineligible employees:  Yes  No Explain \_\_\_\_\_  
 12. Are any persons to be covered retired, currently hospitalized, disabled, or on extension of benefits?  
 Yes  No If yes, give details \_\_\_\_\_  
 13. Are all employees to be insured covered by Workers Compensation?  Yes  No  
 14. Current Life Insurance Carrier \_\_\_\_\_ Will this insurance replace existing insurance?  Yes  No  
 15. Percentage of premium paid by employer: Life & AD&D \_\_\_\_\_% STD \_\_\_\_\_% LTD \_\_\_\_\_% Dep. Life \_\_\_\_\_%

**COVERAGE INFORMATION Groups with 2 – 9 Lives Only**

16. **Life and AD&D**  
 Flat Amount Plan:  \$10,000  \$15,000  \$20,000  \$30,000  \$40,000  \$50,000  
 Class Plan: Class 1. \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 Class 2. \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 Class 3. \_\_\_\_\_ Amount \$ \_\_\_\_\_  
 17. **Dependent Life**  No  Yes (Spouse \$2,000; Children \$1,000; 14 days - 6 months \$200)  
 18. **Short Term Disability**  No  Yes  
 Flat Amount Plan:  \$200/week Benefit Period:  13 weeks  26 weeks  
 Percent of Earnings:  60% to a maximum of \$600/week Benefits Begin: 1<sup>st</sup> day Accident; 8<sup>th</sup> day illness

**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 application.  
 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 or she 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 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 \_\_\_\_\_ Agent Code \_\_\_\_\_ - \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_

**LIFE SPECIFICATIONS *Groups of 10 and Above Only***

**19. Life Insurance and Accidental Death & Dismemberment**

Class Definitions (describe below)	Basic Life/AD&D	Dependent Life Insurance
Class 1. _____	\$ _____	_____ Yes _____ No
Class 2. _____	\$ _____	(\$5000 )
Class 3. _____	\$ _____	
Class 4. _____	\$ _____	

- Notes: A. Basic Life & AD&D Benefits reduce 35% at age 65, and then to 50% at age 70. Benefits terminate at retirement.  
 B. Waiver of Premium is provided as a continuation of Life Benefits in the event of total disability  
 C. An Accelerated Death Benefit is included.

**DISABILITY SPECIFICATIONS *Groups of 13 and Above Only***

**20. Short Term Disability**

Class Definitions (describe below)	Benefits	Accident (Days)	Illness (Days)	Duration (Weeks)
Class 1. _____	_____	_____	_____	_____
Class 2. _____	_____	_____	_____	_____
Class 3. _____	_____	_____	_____	_____
Class 4. _____	_____	_____	_____	_____

**21. Long Term Disability (MINIMUM OF 6 EMPLOYEES TO BE ELIGIBLE)**

Class Definitions (describe below)	Benefits	Maximum Benefit (monthly)	Minimum Benefit (monthly)	Elimination Period (days)	Maximum Duration (years)
Class 1. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 2. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 3. _____	_____ %	\$ _____	\$ _____	_____	_____
Class 4. _____	_____ %	\$ _____	\$ _____	_____	_____

22. Benefit Integration will be as follows:

- Primary & Family Social Security (standard)
- Primary Social Security
- Primary & Family Social Security with 70% all Sources

23. Pre-existing Conditions Exclusion:

- 12/12 (Groups 6 - 24)
- 3/6/12 (Groups 25 and greater)

24. Optional policy features to be included are: \_\_\_\_\_

**APPLICANT'S SIGNATURE**

Quotations were based upon 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 initial deposit is at least equal to the first month's premium, and 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. Only Companion Life's Home Office has the authority to guarantee the acceptability of the requested insurance.

Signature of Applicant/Title \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Agent \_\_\_\_\_ Agent Code \_\_\_\_\_ - \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at [contact@hcrcompliance.com](mailto:contact@hcrcompliance.com) or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

---

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

---

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188]。 (Chinese)

---

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

---

이 건보함에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

---

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

---

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

---

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

---

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190. (French)

---

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

---

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

---

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

---

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

---

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

---

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

---