GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

☐ New Employee
☐ Add/Increase Coverage
☐ Change Beneficiary
☐ COBRA
☐ Change Address
☐ Change Dependent Coverage
☐ Change Class or Status
☐ Terminate Coverage

Companion Use Only
Approved: ☐ Declined: ☐
Date:_____
By:_____

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application) | Group No. (13 digit #) | DEPT/DIV | CLASS

TO BE COMPLETED BY EMPLOYEES

Social Security Number	Effective Date (Month / Day / Year)	Date Employed Full Time (Month / Day / Year)	Date of Birth (Month / Day / Year)	Hours Worked Per Week

Your Name: Last First M.I.

Sex: ☐ Female ☐ Male

☐ Weekly ☐ Monthly ☐ Annually (Do not include overtime or bonuses.)
Earnings $_____

Marital Status: ☐ Single ☐ Married

Occupation

Your Home Address City State Zip Code

COMPLETE FOR LIFE AND/OR DISABILITY

COVERAGE REQUESTED ☐ Basic Life Insurance ☐ AD&D ☐ Dependent Life Insurance ☐ Short Term Disability
☐ Long Term Disability ☐ Voluntary LTD

☐ Voluntary Life
(Amount Selected)

	Life	AD&D
EMPLOYEE:	$	$
SPOUSE:	$	$
CHILD:	$	

Spouse Name: Last First Middle
(Voluntary Life Only)

Birthdate | Social Security Number

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage.)*
Last First Middle Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION

Coverage Requested:
☐ Dental For Employee Only
☐ Vision For Employee Only
☐ Dental For Employee and Dependents
☐ Vision For Employee and Dependents

Is your spouse to be covered? ☐ **Yes** ☐ **No**

Dental and/or Vision Coverage Is For (Check Box Below):
☐ Employee | ☐ Employee plus 1 (☐ Spouse or ☐ Child) | ☐ Employee plus 2 (☐ Spouse ☐ Child or ☐ 2 Children) | ☐ Employee plus 3 or more

Are you or any of your dependents covered for dental insurance under another policy? ☐ Yes ☐ No

Complete for Dependent Coverage	**Full-time Student Y/N**	**Date of Birth**	**Gender M or F**	**Do any of your dependents have any other dental coverage?**	**If Yes, Name of Carrier**
Spouse Name (Last) (First) (Middle Initial)		/ /		☐ Yes ☐ No	
CHILDREN 1		/ /		☐ Yes ☐ No	
CHILDREN 2		/ /		☐ Yes ☐ No	
CHILDREN 3		/ /		☐ Yes ☐ No	

FRAUD WARNING (Not Applicable in AZ, FL, GA, 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.

I elect the above coverage which I have checked from those for which I am eligible, and I decline the above coverage which I have not checked from those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the contribution from my wages.

Date	Your Signature
	X

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.