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COMMITMENT



A Lifetime of Commitment

Companion Life Insurance Company
P.O. Box 100102
Columbia, SC 29202-3102
1-800-753-0404



EMPLOYER INFORMATION

- FULL LEGAL NAME OF EMPLOYER (as it should appear in policy) _____ Telephone Number (_____) _____
Area Code
- EMPLOYER'S FEDERAL TAX ID NUMBER _____ Full Years in Business: _____
Type of Business: _____
ie: Partnership, Sole Proprietorship, Corporation, etc.
- ADDRESS Street _____ Post Office Box _____ Zip _____
City _____ County _____ State _____ Zip _____
- ADMINISTRATIVE CORRESPONDENCE with the applicant should be addressed to:
Name _____ Title _____
- NATURE OF BUSINESS _____
- REQUESTED EFFECTIVE DATE (12:01 a.m.): _____, 20 _____
- PREMIUMS ARE TO BE PAID MONTHLY.
- 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: _____
- Type of Administration: Home Office-administered Self-administered MGU/TPA/GBA administered _____
- Will the requested insurance replace existing insurance? Yes No If YES, give coverage, name of existing carrier, and proposed termination date: _____

EMPLOYEE ELIGIBILITY

- The normal work week for full-time employees is _____ hours.
Eligibility: All regular full-time employees working a minimum of _____ hours per week.
(The minimum work week for full-time employees to be eligible for benefits is 30 hours. Employees working less than 30 hours per week may be acceptable for Life and STD. Contact Companion Life for approval. LTD requires a minimum of 30 hours per week.)
- The employee waiting period for participation is:
 None (effective on next billing date).
 After _____ days of continuous employment (30, 60, etc.).
 After _____ months of continuous employment (1, 2, etc.).
- Current eligible employees are to be covered immediately.
- Employees hired after the plan effective date are to be covered:
 First of the month following completion of the waiting period.
 Fifteenth of the month following completion of the waiting period.
- Number of Eligible Employees: _____
- Number of Enrolled Employees: _____
- SCHEDULE OF BENEFITS (If space provided is inadequate, please attach additional page.)

CLASS DEFINITIONS (Describe Below)	BASIC LIFE /AD&D	SUPPLEMENTAL LIFE /AD&D	SHORT TERM DISABILITY	LONG TERM DISABILITY	VOLUNTARY STD	VOLUNTARY LTD
Percent of Premium Paid by Employer	%	%	%	%	%	%

SPECIFICATIONS FOR INSURANCE

18. Are there any ineligible classes or divisions? Yes No If YES, please describe: _____

19. Are any eligible employees disabled at this time? Yes No If YES, please describe: _____

20. Is a Section 125 Plan in effect? Yes No

Indicate which Companion Life Benefits will be subject to the Section 125 Plan?

Life & AD&D STD LTD Dental Voluntary Life Voluntary STD Voluntary LTD Voluntary Dental None

21. BASIC LIFE AND AD&D BENEFITS reduce as follows (select one):

- 35% at age 65, 50% at age 70, and then 75% at age 75. Benefits terminate when employee is no longer actively at work.
- 35% at age 65, 50% at age 70. Benefits terminate when employee is no longer actively at work.
- 50% at age 70, and then 70% at age 75. Benefits terminate when employee is no longer actively at work.
- ____% at age ____ and then ____% at age ____ and then ____% at age ____ . Benefits terminate when employee is no longer actively at work.

22. SUPPLEMENTAL LIFE AND AD&D BENEFITS reduce as follows (select one):

- 35% at age 65, 50% at age 70 and then 75% at age 75. Benefits terminate when employee is no longer actively at work.
- 35% at age 65, 50% at age 70. Benefits terminate when employee is no longer actively at work.
- 50% at age 70 and then 70% at age 75. Benefits terminate when employee is no longer actively at work.

23. THE REDUCTION SCHEDULES above must be the same as shown in your quotation; otherwise, the rates quoted are subject to review.

24. AD&D BENEFITS Yes No

25. BASIC LIFE AND AD&D guaranteed issue amount: \$ _____ SUPPLEMENTAL LIFE guaranteed issue amount: \$ _____

26. DEPENDENT LIFE BENEFITS Yes No

- A. Spouse Amount: \$ _____ (Cannot exceed 50% of employee's Life amount)
- B. Maximum Child Amount: \$ _____ (Cannot exceed 50% of employee's Life amount)
- C. Coverage for children continues until age _____, or to age _____ if a full-time student.
- D. Percent of Premiums paid by Employer: _____%

27. SHORT TERM DISABILITY (STD) BENEFITS Yes No (Excludes Occupational injury or sickness)

- A. Benefits are payable from _____ day accident and _____ day sickness for maximum of _____ weeks.
- B. For Benefits expressed as a Flat Amount, the Maximum Benefit will be the lesser of the Flat Amount or 70% of weekly earnings.

28. VOLUNTARY STD Yes No Buy-Up Plan Yes (Select benefit plan below. Must match STD Plan #27A above.)

- A. Enrollment minimum of 5 employees
- B. Full Maternity coverage is included \$10,000 Accidental Death Benefit included
- C. A 12/12 Pre-existing condition exclusion applies
- D. Voluntary STD coverage excludes Occupational injury or sickness
- E. The coverage is not available if another STD program from Companion Life is in force (except Buy-Up Plan).
- F. Buy-Up Plan: Employer purchases \$100/wk STD Plan for all eligible employees.

G. Employer's Plan Selected: **1st Plan** **2nd Plan (if applicable)** **Buy-Up Plan Option (if selected)**
 (Enter plan number in box.) (Only for employers with 100 or more eligible employees) (Employees may purchase additional Voluntary STD benefit.)

Benefits Begin

Plan Selected	Accident	Sickness	Duration
Plan 1	1st Day	8th Day	13 Weeks
Plan 2	8th Day	8th Day	13 Weeks
Plan 3	15th Day	15th Day	13 Weeks
Plan 4	1st Day	8th Day	26 Weeks
Plan 5	8th Day	8th Day	26 Weeks
Plan 6	15th Day	15th Day	26 Weeks
Plan 7	15th Day	15th Day	52 Weeks
Plan 8	30th Day	30th Day	52 Weeks

29. TRUE GROUP LONG TERM DISABILITY BENEFITS Yes No
- A. Benefits are payable after an Elimination Period of _____ days. B. Benefits are _____ % of Basic Monthly Earnings.
- C. Maximum Monthly Benefit is not to exceed \$ _____ . D. Minimum Monthly Benefit is \$ _____ .
- E. Maximum Benefit period will be: To Age 65 (Reducing Benefit Duration) 5 Years 2 Years
- F. Own Occupation Definition: 2 Year 3 Year 5 Year Extensive (to age 65)
- G. Benefit integration will be as follows: Primary and Family Social Security (standard) Primary Social Security
- H. Optional Policy Features to be included are:
 Specified as follows: _____

- I. Pre-Existing Condition Exclusion: (10-24 Lives)
Standard: 12/6/24 not available in CO, FL, MD, MS, MT, PA, SC, WI, WV
FL & PA: 3/6/12
Others: 12/12
- (25+ Lives)
Standard: 3/6/12

30. VOLUNTARY LONG TERM DISABILITY BENEFITS Yes No

Companion Cornerstone Plan

- A. Maximum Benefit period will be: Two Years/Reducing Benefit Duration or Five Years/Reducing Benefit Duration
- B. Elimination Period: 90 days or 180 days
- C. All employees receive coverage equal to 60% of their earnings to a maximum monthly benefit of \$3,000.
- D. Enrollment minimum of 5 employees of 25% eligible group, whichever is greater.
- E. Pre-Existing Condition Exclusion: (10-24 Lives)
Standard: 12/6/24 not available in CO, FL, MD, MS, MT, PA, SC, WI, WV
FL & PA: 3/6/12
Others: 12/12

31. SPECIAL REQUESTS/INSTRUCTIONS: _____

EMPLOYER'S SIGNATURE

PLEASE READ CAREFULLY

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

Dated at _____ this _____ day of _____, 20 _____

(Signature of Employer) (Title) (Witness)

AGENT'S REPORT

32. INITIAL DEPOSIT (Minimum first month's premium is required.): \$ _____
33. Are all the employees to be insured for Disability Income covered by Workers' Compensation? Yes No
If NO, explain: _____
34. 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: _____
35. 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): _____
36. Is Agent or Broker licensed in the State of this group for the types of insurance solicited? Yes No
37. To the best of the Agent's or Broker's knowledge, replacement is is not involved with this transaction.
38. Print name of Agent/Broker _____
39. Signature of Agent/Broker _____ Date _____

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.