



EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

LTD 1-800-753-0404

EMPLOYER INFORMATION

Legal Name of Employer _____ Tax I.D. Number _____
Address _____ City _____ State _____ Zip _____
Telephone () _____ Firm Contact _____ Title _____
(person to contact concerning coverages)
Employees Eligible: _____ # Eligible Employees Enrolled: _____ # Family Members in Firm: _____
Type of Business - i.e. sole proprietorship, partnership, corporation, etc.: _____
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? _____
Will this insurance replace existing insurance? _____ Name of existing carrier _____

Waiting Period Initial Enrollment Future Employees (Minimum 3 Months)
[] Immediately [] Other _____ [] 3 months [] Other _____

[] All Industry Plan
Benefit Percentage 60% of Earnings
Maximum Payment Amount \$6,000 per month
Benefit \$ _____
Elimination Period 180 Days
Maximum Payment Duration Two Years/RBD
Percent of premium paid by employer _____ %

[] 5 Year/Reducing Benefit Duration (RBD) Plan
Benefit Percentage 60% of Earnings
Maximum Payment Amount \$6,000 per month
Benefit \$ _____
Elimination Period [] 90 Days [] 180 Days
Maximum Payment Duration Five Years/RBD
Percent of premium paid by employer _____ %

[] Age 65/Reducing Benefit Duration (RBD) Plan
Benefit Percentage 60% of Earnings
Maximum Payment Amount \$6,000 per month
Benefit \$ _____
Elimination Period [] 90 Days [] 180 Days
Maximum Payment Duration Age 65/RBD
Percent of premium paid by employer _____ %

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, P.O. Box 100102, Columbia, SC 29202-3102, 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 _____