Companion Life

EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

LTD
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
☐ 90 Days ☐ 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 ________