Service
Quality
Flexibility...

COMMITMENT

A Lifetime of Commitment
Companion Life Insurance Company
P.O. Box 100102
Columbia, SC 29202-3102
800-753-0404
APPLICATION FOR GROUP LIFE, AD&D, SHORT TERM AND LONG TERM DISABILITY INSURANCE, VOLUNTARY STD, LTD AND CRITICAL ILLNESS

EMPLOYER INFORMATION

1. FULL LEGAL NAME OF EMPLOYER (as it should appear in policy) ____________________________ Telephone Number ( ) __________ Area Code __________

2. EMPLOYER’S FEDERAL TAX ID NUMBER ____________________________

Type of Business ____________________________
i.e.: Partnership, Sole Proprietorship, Corporation, etc.

3. ADDRESS Street ____________________________ Post Office Box __________ ZIP __________

City ____________________________ County ____________________________ State ____________________________ ZIP __________

4. ADMINISTRATIVE CORRESPONDENCE with the applicant should be addressed to

Name ____________________________ Title ____________________________

5. NATURE OF BUSINESS ____________________________

6. REQUESTED EFFECTIVE DATE (12:01 a.m.) ____________________________ 20 __________

7. PREMIUMS ARE TO BE PAID MONTHLY.

8. 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 ____________________________

9. Type of Administration ☐ Home Office administered ☐ Group Administered (minimum 250 lives) ☐ MGU/TPA/GBA Administered

10. Will the requested insurance replace existing insurance? ☐ Yes ☐ No

If YES, give coverage, name of existing carrier and proposed termination date ____________________________

EMPLOYEE ELIGIBILITY

11. 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 fewer 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.)

12. 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.).

14. 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.

☐ Immediately.

15. Number of eligible employees ____________________________

16. Number of enrolled employees ____________________________

17. SCHEDULE OF BENEFITS (If space provided is inadequate, please attach additional page.)

<table>
<thead>
<tr>
<th>CLASS DEFINITIONS (Describe Below)</th>
<th>BASIC LIFE /AD&amp;D</th>
<th>SHORT TERM DISABILITY</th>
<th>LONG TERM DISABILITY</th>
<th>VOLUNTARY STD</th>
<th>VOLUNTARY LTD</th>
<th>VOLUNTARY CRITICAL ILLNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ All full-time employees</td>
<td>Benefit Amount: $ ________</td>
<td>Plan: _____ / _____ / _____</td>
<td>________ %</td>
<td>Plan: _____ / _____ / _____</td>
<td>_____ %</td>
<td>Region: ____________________________</td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
<td></td>
<td>Max $ ________</td>
<td>Max $ ________</td>
<td>Elimination Period:</td>
<td>Max $ ________</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Pre-Ex:</td>
<td></td>
</tr>
</tbody>
</table>

Percent of Premium Paid by Employer % % % %

If a Section 125 Plan is in effect, please complete Question 20.

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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 □ N/A  
If yes, please indicate which Companion Life Benefits will be subject to the Section 125 Plan and note the employer’s and employee’s contributions.

□ Life & AD&D □ STD □ LTD □ Voluntary Life □ Voluntary STD □ Voluntary LTD □ Critical Illness
ER______% ER______% ER______% ER______% ER______% ER______% ER______% ER______%  
EE______% EE______% EE______% EE______% EE______% EE______% EE______% EE______%

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.  
□ ______% at age ______ and then ______% at age ______ and then ______% at age ______.  
Benefits terminate when employee is no longer actively at work.

22. BASIC LIFE AND AD&D guaranteed issue amount $ __________

23. DEPENDENT LIFE BENEFITS □ Yes □ No  
A. Spouse Amount $ __________ (Cannot exceed the lesser of 50% of employee’s Life amount or $10,000.)
B. Maximum Child Amount $ __________ (Cannot exceed the lesser of 50% of employee’s Life amount or $10,000.)
C. Coverage for children continues until age ________, or until age ________ if a full-time student.
D. Percent of premiums paid by employer ________%

24. 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.

25. VOLUNTARY STD □ Yes □ No  Buy-Up Plan □ Yes  (Select benefit plan below. Must match STD Plan #24A above.)
A. Enrollment minimum of five employees
B. Full maternity coverage is included
C. $10,000 accidental death benefit is included
D. A 12/12 pre-existing condition exclusion applies
E. Voluntary STD coverage excludes occupational injury or sickness
F. The coverage is not available if another STD program from Companion Life is in force (except Buy-Up Plan)
G. Buy-Up Plan: Employer purchases $100/wk STD Plan for all eligible employees
H. 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**

<table>
<thead>
<tr>
<th>Plan Selected</th>
<th>Accident</th>
<th>Sickness</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 1</td>
<td>1st Day</td>
<td>8th Day</td>
<td>13 Weeks</td>
</tr>
<tr>
<td>Plan 2</td>
<td>8th Day</td>
<td>8th Day</td>
<td>13 Weeks</td>
</tr>
<tr>
<td>Plan 3</td>
<td>15th Day</td>
<td>15th Day</td>
<td>13 Weeks</td>
</tr>
<tr>
<td>Plan 4</td>
<td>1st Day</td>
<td>8th Day</td>
<td>26 Weeks</td>
</tr>
<tr>
<td>Plan 5</td>
<td>8th Day</td>
<td>8th Day</td>
<td>26 Weeks</td>
</tr>
<tr>
<td>Plan 6</td>
<td>15th Day</td>
<td>15th Day</td>
<td>26 Weeks</td>
</tr>
<tr>
<td>Plan 7</td>
<td>15th Day</td>
<td>15th Day</td>
<td>52 Weeks</td>
</tr>
<tr>
<td>Plan 8</td>
<td>30th Day</td>
<td>30th Day</td>
<td>52 Weeks</td>
</tr>
</tbody>
</table>

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26. TRUE GROUP LONG TERM DISABILITY BENEFITS  

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  
   □ SSNRA (Reducing Benefit Duration)  
   □ To age 65  
   □ 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  

27. VOLUNTARY CRITICAL ILLNESS  

□ Yes  □ No  
Enrolled employees will have the following Critical Illness Benefit Amount:  
   □ $5,000 (10+ eligible ees)  
   □ $10,000 (25+ eligible ees)  
   □ $15,000 (100+ eligible ees)  
   □ $20,000 (200+ eligible ees)  

Benefits reduce 25% at age 60 and 50% at age 65; benefits terminate at retirement.  

28. VOLUNTARY LONG TERM DISABILITY BENEFITS  

□ Yes  □ No  

Companion Cornerstone Plan  
A. Maximum benefit period will be  
   □ SSNRA (Reducing Benefit Duration)  
   □ To age 65  
   □ 5 Years  
   □ 2 Years  
B. Elimination period  
   □ 90 days  
   □ 180 days  
   □ Other  
C. All employees receive coverage equal to ________% of their earnings to a maximum monthly benefit of $__________, limited to a maximum of $6,000.  
D. Pre-existing condition limitation:  
   (10-24 Lives)  
   □ Standard: 12/6/24  
   □ FL & PA: 3/6/12  
   □ Others: 12/12  
   (25+ Lives)  
   □ Standard: 3/6/12  

29. 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  

30. INITIAL DEPOSIT (Minimum first month’s premium is required.)  
   $___________.  

31. Are all the employees to be insured for Disability Income covered by Workers’ Compensation?  
   □ Yes  □ No  
   If NO, explain __________________________.  

32. 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 __________________________.  

33. 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)  
   __________________________.  

34. Is agent or broker licensed in the state of this group for the types of insurance solicited?  
   □ Yes  □ No  

35. To the best of the agent’s or broker’s knowledge, replacement  
   □ is  □ is not involved with this transaction.  

36. Print name of agent/broker __________________________.  

37. 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.