



Companion Life

Companion Life Insurance Company, Columbia, South Carolina
P.O. Box 100102 • Columbia, SC 29202-3102

**VOLUNTARY GROUP TERM LIFE INSURANCE
ENROLLMENT FORM**

Companion Use Only

Approved: Declined:

Date: _____

By: _____

PART A

Employer Name: _____ Group Number: _____ Division: _____

Social Security Number: _____ Effective Date: _____ Date of Hire: _____ Work Hours per Week: _____ Annual Salary: \$ _____

Employee Name: Last _____ First _____ Middle _____ Birthdate: _____ Female:
Male:

Coverage Amount Selected: Life AD&D EMPLOYEE: \$ _____ \$ _____ SPOUSE: \$ _____ \$ _____ DEPENDENT: \$ _____
 Initial application
 Increase in coverage

EMPLOYEE Address: _____

Employee Occupation: _____

Spouse Name: Last _____ First _____ Middle _____ Birthdate: _____ Social Security Number: _____

Beneficiary for Employee Coverage/Relationship: _____ Mailing Address: _____
(Employee is beneficiary for spouse coverage.)
Name / Relationship _____

In Community Property states, 50% of the payable benefit will be paid to the spouse unless the spouse signs a notarized statement waiving the rights to these proceeds.

I hereby apply for Voluntary Group Term Life Insurance under the provisions of the Group Policy for which I am eligible and authorize deductions from my wages to cover the cost of the insurance.

Date: _____ Signature: _____

If you are declining coverage, sign below and return this form to your employer. Do not complete Part B.

WAIVER OPTION

I acknowledge that I have been offered Voluntary Group Term Life Insurance issued by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, if I should apply at a later date.

Date: _____ Signature: _____

PART B

This section to be completed only if requesting amounts over the Guarantee Issue Amount, requesting an increase in insurance, or if you are a late enrollee. If you are declining coverage, do not complete this section. **Please answer every question/complete every space.**

Name and address of the Doctor or facility that has your medical records. Employee's Doctor: _____ Spouse's Doctor: _____ Child's Doctor: _____
Address: _____ Address: _____ Address: _____

Employee: Height: _____ Weight: _____ Spouse: Height: _____ Weight: _____
Have you gained or lost more than 20 pounds in the last year?
 Yes No
If yes, amount gained or lost: _____ pounds.
(Explain below)

Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required.

	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
1. Has Proposed Insured:						
a. Ever had an application for life or health insurance, or for reinstatement thereof, declined or modified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Ever applied for or received any disability compensation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Smoked cigarettes in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Flown or intended to fly as a pilot, student pilot or crew member?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you now actively employed on a full time basis (30 hours or more per week)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. To the best of your knowledge and belief, do you have any physical impairment or disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Within the past 5 years, have you been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for:						
a. coronary artery disease, abnormal blood pressure, diabetes or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genitourinary or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. drug or alcohol dependency or abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any surgical operations or had surgery advised but not performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. To the best of your knowledge and belief, are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Give the name and address of your personal physician and the date and reason for your last consultation						
Name _____ Address _____ Date: _____ Reason: _____						
9. Details in connection with questions 3 - 6 answered "YES" above.						

Question Number	Date Mo. Yr.	Give Full Details for Each Question Answered "Yes" Including such information as Nature of Illness or Injury, Number of Attacks, Duration, Severity, Treatment, Results and any Other Pertinent Information	Name and Address of Physician or Hospital

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.

I have read the statements on this application and agree that the above answers are complete and true to the best of my knowledge and belief. I acknowledge receipt and understanding of the "Notice of Exchange of Information" explained on the back of this form. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give Companion Life Insurance Company or its reinsurers any such information. A photographic copy of this authorization shall be valid as the original.

Date: _____ Signature: _____

NOTICE OF EXCHANGE OF INFORMATION

Thank you for enrolling for Voluntary Group Term Life Insurance with Companion Life Insurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. Companion Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit organization of life insurance companies which operates as information exchange in behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file (Medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Companion Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.