



**Companion Life Insurance Company**  
 P.O. Box 100102 • Columbia, S.C. 29202 • (803) 735-1251

- New Employee
- Add Coverage
- Change Dependent Coverage
- Change Beneficiary
- Change Address (Dental)
- Change Class or Status
- Terminate Employee

**GROUP INSURANCE ENROLLMENT FORM AND CHANGE REQUEST**

Please Type or Print Clearly

**TO BE COMPLETED BY EMPLOYER**

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group No. (13 digit #)	DEPT/DIV	CLASS

**TO BE COMPLETED BY ALL EMPLOYEES**

Social Security No.			Effective Date			Date Employed Full Time			Hours Worked Per Week
			Month	Day	Year	Month	Day	Year	
Your Name Last First M.I.				Date of Birth			Sex		
				Month	Day	Year	<input type="checkbox"/> Female <input type="checkbox"/> Male		
<input type="checkbox"/> Weekly Earnings <input type="checkbox"/> Monthly <input type="checkbox"/> Annually \$ _____ (Do not include overtime or bonuses.)			Marital Status		Occupation				
			<input type="checkbox"/> Single <input type="checkbox"/> Married						

**COMPLETE FOR LIFE AND/OR DISABILITY**

COVERAGE REQUESTED  Basic Life     AD&D     Supplemental AD&D     Short Term Disability  
 Dependent Life     Supplemental Life – (Amount Requested \$ \_\_\_\_\_)     Long Term Disability  
 (If you decline coverage, complete **Refusal of Group Insurance** section.)     Voluntary LTD

Name of Beneficiary (Show as Mary S. Brown not as Mrs. William Brown.)  
 Last First Middle Relationship to Insured

**COMPLETE FOR DENTAL**

Is your spouse to be covered?  Yes  No

Dental Coverage Is For: <input type="checkbox"/> Employee <input type="checkbox"/> Employee plus 2 <input type="checkbox"/> Employee plus 1 <input type="checkbox"/> Employee plus 3 or more (If you decline coverage, complete <b>Refusal of Group Insurance</b> section.)	Are you covered by other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If spousal coverage is requested, is your spouse covered by other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Your Spouse's Date of Birth Month Day Year

Your Home Address City State Zip Code

**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.

I elect the above coverage which I have checked from those for which I am eligible, and I decline the above coverage which I have not checked from those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the contribution from my wages.

Date	Your Signature
	X

**REFUSAL OF GROUP INSURANCE**

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Coverage Refused (Check All That Apply):  Basic Life     AD&D     Supplemental AD&D     Supplemental Life  
 Dependent Life     Short Term Disability     Long Term Disability     Employee Dental     Voluntary LTD

Date \_\_\_\_\_ Signature of Employee \_\_\_\_\_