GROUP APPLICATION

Service
Quality
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COMMITMENT

Companion Life

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 on policy) _____

   Telephone Number ( ) _____ (Area Code)

   Full Years in Business _____

2. EMPLOYER'S FEDERAL TAX ID NUMBER _____

   Email Address _____

   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 workweek for full-time employees is _____hours.
    Eligibility: All regular full-time employees working a minimum of _____hours per week.
    (The minimum workweek 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.).

13. Current eligible employees are to be covered immediately.

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.)

CLASS DEFINITIONS (Describe Below)	BASIC LIFE /AD&D	SHORT TERM DISABILITY	LONG TERM DISABILITY	VOLUNTARY STD	VOLUNTARY LTD	VOLUNTARY CRITICAL ILLNESS
☐ All full-time employees ☐ Other _____ _____ _____ _____	Benefit Amount: $ _____	Plan: ___/___/____ _____% Max $ _____	_____% Max $ _____ Elimination Period: _____ Pre-Ex: _____	Plan: ___/___/____	_____% Max $ _____ Elimination Period: _____ Pre-Ex: _____	Region: _____ Benefit Amount: $ _____
Percent of Premium Paid by Employer	%	%	%	%	%	%

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

SPECIFICATIONS FOR INSURANCE

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_____%
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 (Enter plan number in box.) **1st Plan** ☐ **2nd Plan (if applicable)** (Only for employers with 100 or more eligible employees) ☐ **Buy-Up Plan Option (if selected)** (Employees may purchase additional Voluntary STD benefit.) ☐

Plan Selected	Benefits Begin Accident	Sickness	Duration
Plan 1	1st Day	8th Day	13 Weeks
Plan 2	8th Day	8th Day	13 Weeks
Plan 3	15th Day	15th Day	13 Weeks
Plan 4	1st Day	8th Day	26 Weeks
Plan 5	8th Day	8th Day	26 Weeks
Plan 6	15th Day	15th Day	26 Weeks
Plan 7	15th Day	15th Day	52 Weeks
Plan 8	30th Day	30th Day	52 Weeks

26. TRUE GROUP LONG TERM DISABILITY BENEFITS ☐ Yes ☐ No

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 _____

_____

_____

I. Pre-existing condition limitation: (10-24 Lives) Standard: 12/6/24, not available in CO, FL, MD, MS, MT, PA, SC, WI, WV
FL & PA: 3/6/12 Others: 12/12 (25+ Lives) Standard: 3/6/12

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 not available in CO, FL, MD, MS, MT, PA, SC, WI, WV
FL & PA: 3/6/12
Others: 12/12

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 _____ (City/State) 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) that 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 _____

See Last Pages Companion Life Form 95734 for Fraud Notices

GENERAL FRAUD WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN R.S.A. 638:20.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)