



GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life Insurance Company

P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

- ☐ New Employee
☐ Add/Increase Coverage
☐ Change Beneficiary
☐ COBRA
- ☐ Change Address
☐ Change Dependent Coverage
☐ Change Class or Status
☐ Terminate Coverage

Companion Use Only

Approved: ☐ Declined: ☐

Date: _____

By: _____

TO BE COMPLETED BY EMPLOYER		Group No. (10 digit #)	DEPT/DIV (3 digit #)	CLASS
Name of Employer (Use Name from Group Billing Notice or Master Application)				

TO BE COMPLETED BY EMPLOYEES				
Social Security Number	Effective Date Month / Day / Year	Date Employed Full-time Month / Day / Year	Date of Birth Month / Day / Year	Hours Worked Per Week
Your Name Last First M.I.		Sex ☐ Female ☐ Male	☐ Weekly ☐ Monthly ☐ Annually Earnings \$ _____ *	*Do not include overtime or bonuses
Marital Status ☐ Single ☐ Married	Occupation	Your Home Address Street Apt/Suite No. City State ZIP Code		

COMPLETE FOR LIFE AND/OR DISABILITY				
COVERAGE REQUESTED ☐ Basic Life ☐ AD&D ☐ Dependent Life ☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary Life ☐ Voluntary Long Term Disability				
Voluntary Life Voluntary AD&D Voluntary Life Voluntary AD&D Voluntary Life				
(Amount Selected)	EMPLOYEE: \$ _____ \$ _____	SPOUSE: \$ _____ \$ _____	CHILD: \$ _____	
Spouse Name: Last / First / M.I. (Voluntary Life Only)		Birthdate (M/D/Y)	Social Security Number	
Beneficiary for Employee Coverage/Relationship: (Employee is beneficiary for spouse coverage.) Last First M.I. Relationship to Insured				

COMPLETE FOR DENTAL AND/OR VISION				
Coverage Requested: ☐ Dental for Employee Only ☐ Vision for Employee Only ☐ Dental for Employee and Dependents ☐ Vision for Employee and Dependents				
Is your spouse to be covered? ☐ Yes ☐ No	Dental and/or Vision Coverage Is For (Check Box Below): ☐ Employee ☐ Employee plus Spouse ☐ Employee plus Child(ren) ☐ Family			Are you or any of your dependents covered for dental insurance under another policy? ☐ Yes ☐ No

Complete for Dependent Coverage		Date of Birth M / D / Y	Gender M or F	Do any of your dependents have any other dental coverage? ☐ Yes ☐ No	If Yes, Name of Carrier
Spouse Name (Last / First / M.I.)					
CHILDREN	1)			☐ Yes ☐ No	
	2)			☐ Yes ☐ No	
	3)			☐ Yes ☐ No	
	4)			☐ Yes ☐ No	

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 ☐ Dependent Life ☐ Short Term Disability ☐ Long Term Disability ☐ Dental ☐ Vision ☐ Voluntary Life ☐ Voluntary Long Term Disability ☐ Voluntary Dental	

FRAUD WARNING (Not Applicable in AZ, FL, GA, 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.

Date	Your Signature X
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NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.