GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life

Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202-3102
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

Administered by:
SECUREONE Benefit Administrators, Inc.

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

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

Marital Status ☐ Single ☐ Married

Your Home Address — Street / Apt/Suite No. / City / State / ZIP Code

COMPLETE FOR DENTAL

Dental Coverage Is For (Check Box Below):

☐ Employee ☐ Employee plus Spouse ☐ Employee plus Child(ren) ☐ Family

Are you covered for dental insurance under another policy? ☐ Yes ☐ No

If yes, name of carrier _____

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

☐ 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

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.