**EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST**

**FOR USE IN SOUTH CAROLINA ONLY**

1-800-753-0404

**EMPLOYER INFORMATION**

Firm Name ____________________

Address ____________________ City ____________ State ________ Zip ________

Telephone (    ) ____________ Firm Contact ____________________ Title ____________
(person to contact concerning coverages)

# Full-time Employees in Firm: ____________ # Full-time Employees Enrolled: ____________

Effective Date Requested: ____________ SIC Code or Nature of Business: ____________
(The firm's effective date will be the first or the 15th of the month following acceptance by Companion Life Insurance Company.)

How many years in this business? ____________ How many years in this location? ____________

Tax I.D. Number ____________ Will this insurance replace existing insurance? ____________

Name of existing carrier ____________ Which coverages are being replaced? ☐ Life and AD&D ☐ STD

☐ Flat Amount Plan
- ☐ $10,000 ☐ $15,000 ☐ $20,000
- ☐ $30,000 ☐ $40,000 ☐ $50,000

Waiting Period Initial Enrollment
- ☐ One month
- ☐ Other: ____________

Waiting Period Future Employees
- ☐ One month
- ☐ Other: ____________

**☐ Life and AD&D**

☐ Class Plan

| Class | Description | Life and AD&D Amount |
|---|---|---|
| 1 | ____________ | $ ____________ |
| 2 | ____________ | $ ____________ |
| 3 | ____________ | $ ____________ |

☐ Dependent Life
- ☐ Yes
- ☐ No

Spouse: $2,000

Children: $1,000

Children 14 days - 6 months: $200

Percent of premium paid by employer _____%
(A minimum of 25% is required.)

**☐ STD**

Percent of Earnings

60% to a maximum benefit of (select one)

☐ $600/week ☐ $______/week

Benefit Period: ☐ 13 weeks ☐ 26 weeks

Benefits Begin: First Day (Accident)
Eighth Day (Illness)

Percent of premium paid by employer ____%
(A minimum of 25% is required.)

| Life and AD&D Total Monthly Premium | | Dependent Life Total Monthly Premium | | STD Total Monthly Premium | | $1.00 per Enrollee* ($5.00 minimum) | | Total Monthly Premium |
|---|---|---|---|---|---|---|---|---|
| $ ________ | + | $ ________ | + | $ ________ | + | | = | $ ________ |

Are any of the persons to be covered retired, currently hospitalized, disabled or on any extension of benefits? ☐ Yes ☐ No (If yes, give details.)

**Participation Agreement (administered and underwritten by Companion Life Insurance Company)**

The Participant does hereby apply for Group Insurance Benefits as set forth in the above "Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

**Name of Trust:** Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does he or she have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy. The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666. ***The undersigned employer agrees that coverage shall not commence until this application has been approved by Companion Life Insurance Company and notice of approval has been transmitted to us.*** As named employer, I understand that I should not cancel any existing coverage until notified that this application has been accepted by Companion Life.

Signature of Applicant ____________________

Title ____________________ Date ________

Signature of Agent/Broker ____________________ Date ________

Printed Name ____________________

FOR HOME OFFICE USE

Accepted by Administrator Effective: ____________

By: ____________

Title ____________ Date ________