

GROUP APPLICATION

Group Life, AD&D, Short Term and
Long Term Disability

Service
Quality
Flexibility ...

COMMITMENT



A Lifetime of Commitment

P.O. Box 100102
Columbia, SC 29202-3102
1-800-753-0404



FOR USE IN SOUTH CAROLINA ONLY

APPLICATION FOR GROUP LIFE, AD&D, SHORT TERM AND LONG TERM DISABILITY INSURANCE

APPLICANT INFORMATION

- 1. FULL LEGAL NAME OF APPLICANT (As it should appear in policy):
2. APPLICANT'S FEDERAL TAX ID NUMBER:
3. ADDRESS: (Street)
4. ADMINISTRATIVE CORRESPONDENCE with the Applicant should be addressed to:
5. NATURE OF BUSINESS
6. REQUESTED EFFECTIVE DATE (12:01 a.m.):
7. PREMIUMS ARE TO BE PAID:
8. Are there subsidiary or affiliate businesses covered under this plan?
9. Type of Administration:

EMPLOYEE ELIGIBILITY

- 10. The normal work week for full-time employees is
11. Current eligible employees are to be covered:
12. Employees hired after the plan effective date are to be covered:
13. Coverage following completion of the waiting period selected will be effective:
14. Number of Eligible Employees:
15. Number of Enrolled Employees:

16. 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
Percent of Premium Paid by Employer	%	%	%

17. Are there any Ineligible Classes or Divisions? Yes No If YES, please describe: _____

SPECIFICATIONS FOR INSURANCE

18. BASIC LIFE AND AD&D BENEFITS reduce as follows:

35% at age 65, and then to 50% at age 70. Benefits terminate at retirement.

19. THE REDUCTION SCHEDULE above should be the same as shown in your quotation; otherwise, the rates quoted are subject to review.

20. WAIVER OF PREMIUM IS PROVIDED AS A CONTINUATION OF LIFE BENEFITS IN THE EVENT OF TOTAL DISABILITY.

21. AN ACCELERATED DEATH BENEFIT IS INCLUDED.

22. BASIC LIFE AND AD&D guaranteed issue amount: \$ _____

23. DEPENDENT LIFE BENEFITS (if selected) are as follows:

- A. Spouse Amount: \$ _____
- B. Child Amount: \$ _____ (Maximum: \$100 for child under 6 months)
- C. Coverage for children continues until age 19, or to age 25 if a full-time student.
- D. Percent of Premiums paid by Employer: _____

24. SHORT TERM DISABILITY BENEFITS: Yes No (Excludes injury or sickness covered by any Workers Compensation Act)

- A. Benefits are payable from _____ day accident and _____ day sickness for _____ weeks.
- B. Maternity Benefits included.
- C. For Benefits expressed as a Flat Amount, the Maximum Benefit will be the lesser of the Flat Amount or 70% of weekly earnings.

25. TRUE GROUP LONG TERM DISABILITY BENEFITS:

- 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. Benefit Integration will be as follows: Primary Social Security. Primary & Family Social Security (standard).
 Primary & Family Social Security with 70% all Sources.
- F. Maximum Benefit Period will be:
 - Reducing Benefit Duration (ADEA approved – standard benefit). 65/5/70
 - _____ years, or to age _____, whichever occurs first. To age _____
 - Other (Please specify): _____

26. TRUE GROUP LONG TERM DISABILITY BENEFITS (continued):

G. Optional Policy Features to be included are:

As specified in the proposal (please attach).

Specified as follows: _____

H. Pre-existing Conditions Exclusion: 12/12 (2-25 Lives) 5 Day
 3/6/12 (Standard 26+ Lives) Other: _____

27. Will this insurance replace existing insurance? Yes No If YES, give name of existing carrier and the proposed termination date:

28. SPECIAL REQUESTS/INSTRUCTIONS: _____

APPLICANT'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 _____ this _____ day of _____, 20 _____
(city/state)

(Signature of Applicant)

(Title)

(Witness)

AGENT'S REPORT

29. INITIAL DEPOSIT (Minimum first month's premium is required.): \$ _____

30. Are all the employees to be insured for disability income covered by Workers Compensation? Yes No

If no, explain: _____

31. 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: _____

32. Is there another group insurance plan(s) which 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 of this plan(s): _____

33. Is Agent or Broker licensed in the state of this group for the types of insurance solicited? Yes No

34. Signature of Agent/Broker _____ Date _____

FRAUD WARNING: 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 is guilty of insurance fraud.