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	______	$ ______

Percent of premium paid by employer ______%

(A minimum of 25% is required.)

☐ Dependent Life
☐ Yes
☐ No

Spouse: $2,000

Children: $1,000

Children

14 days - 6 months: $200

☐ 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*		Total Monthly Premium
$ ______	+	$ ______	+	$ ______	+	($5.00 minimum)	=	$ ______

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 ______