Companion Life Insurance Company
7909 Parklane Road, Suite 200
Columbia, South Carolina 29223-5666

Standard or High Option Employer Application

THIS TYPE OF PLAN IS NOT CONSIDERED 'MINIMUM ESSENTIAL COVERAGE' UNDER THE AFFORDABLE CARE ACT AND THEREFORE DOES NOT SATISFY THE INDIVIDUAL MANDATE THAT YOU HAVE HEALTH INSURANCE COVERAGE. IF YOU DO NOT HAVE OTHER HEALTH INSURANCE COVERAGE, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY.

Application is made to Companion Life Insurance Company for a Dental Policy, the provisions of which shall be made available to all eligible classes of Employees.

General Information

Group Medical Plan Effective Date/ Renewal Date:

Group Medical Plan Number:

Group Medical Plan Account Manager Name and Phone Number:

Dental Plan Effective Date (must be the same as medical plan):

Employer Group Information

Group Name:	Tax Identification Number:

☐ Corporation ☐ Proprietorship ☐ Partnership

Group Legal Name (if different then above):

Group Contact Name and Title:	Group Contact Email:
Group Contact Phone:	Group Fax Number:

Physical Address (P.O. Boxes are not allowed):		Suite Number:	
City:	State:	ZIP Code:	County:

Mailing Address (if different from physical address):		Suite Number:	
City:	State:	ZIP Code:	County:

Nature of Business:	SIC Code:

Affiliates or subsidiaries to be covered
Name:

City	State:	ZIP Code:	County:

Number of eligible employees residing outside of the state in which the policy was issued:
State: _____ Number of Employees: _____

Eligibility

CLASSES OF ELIGIBLE EMPLOYEES:

☐ Active employees - All active full-time employees (A full-time employee must work 30 hours per week of compensable time.)

☐ Other - Explain if there are any persons who will be enrolled who are not actively employed (i.e., retirees, COBRA, etc.):

NUMBER OF ELIGIBLE EMPLOYEES IN ELIGIBLE CLASSES (**minimum of 2 enrolled to qualify**)

A. Total number of employees on the payroll:_____

B. Less number of employees not eligible: _____

C. Total Number Enrolled:_____

DEPENDENT ELIGIBILITY

Spouse and/or children to age 26. If there are any additional eligibility requirements for dependents, please specify:

WAITING PERIOD	ELIGIBILITY
☐ Date of hire ☐ 1st of the month following date of hire ☐ 1st of the month following 30 days of employment ☐ 1st of the month following 60 days of employment ☐ Effective on the 91st date of employment (not eligible for 30-day orientation period) ☐ Group has a 30-day orientation period (waiting period begins after orientation period)	1. Part-time employment applies to waiting period? Yes ☐ No ☐ 2. Group agrees to domestic partner coverage? Yes ☐ No ☐ 3. Group is COBRA eligible? Yes ☐ No ☐ If Yes, COBRA Administrator Name _____

Employer Contributions

PERCENT OR AMOUNT

The Employer agrees to make the following contribution toward the cost of the employee and dependent coverage: Employee _____(% / $) Dependent _____(% / $)

Type of Coverage (select one)

☐ Standard Option		☐ High Option	
☐ PPO-MAC Contributory (employer contributes) ☐ PPO-MAC Voluntary (employee paid)		☐ PRO PPO-MAC Contributory (employer contributes) ☐ PRO PPO-MAC Voluntary (employee paid)	
Standard Option Premiums PPO-MAC		**High Option Premiums PRO-PPO –MAC**	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$26.18 $56.44 $54.59 $82.90	Employee Employee + Spouse Employee + Child(ren) Employee + Family	$32.73 $73.05 $67.22 $99.88

Class III** Waiting Period

****Six (6) Month Class III** Waiting Period Waived?** Yes ☐ No ☑

Take over credit requested for time covered under this employer's prior Plan (plan being replaced)?

Yes ☐ No ☐

If "Yes", a Takeover of Benefits Credit is to be considered for Class III, the following must be provided.

Name of Carrier:_____ Effective Date of Prior Plan:_____

Termination date of Prior Plan:_____

The employer must also submit a copy of (1) the prior carrier's most recent billing statement; (2) a certificate or letter of acceptance that shows the effective date of the prior plan; and (3) the prior carrier's certificate, booklet or schedule of benefits.

Signature

FRAUD WARINING: 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 there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AGREEMENT

A. This application is signed by a person or persons authorized by the Employer to make such an agreement; and
B. The application is received and approved by the Companion Life Insurance Company at its home office; and
C. The initial month's premium is received by Companion Life Insurance Company.

Coverage is effective on the first billing due date after the conditions in (a), (b), and (c) above have been met. Coverage is subject to all the terms and conditions of the Group Dental Policy.

SIGNATURES

For a corporation, the President or Vice President and the Secretary or Acting Secretary should sign. For a proprietorship, the owner should sign. For a partnership, any partner should sign. I have read this application, agreed to the terms, and certify that all statements are true and complete. It is understood that provisions of the Group Dental Policy, including premiums therefore, may be amended or changed from time to time, upon written notice from Companion Life Insurance Company to the Employer.

Employer Representative	Agent/Broker
(print name)	(print name)
(signature)	(signature)
Title	License Number
Date	Date