YOUR LOGO

Voluntary benefits
ENROLLMENT

1. **Complete enrollment form at right.**

2. **Complete *Companion* enrollment form** (NEW participants).

3. **Send to:**
   Resource Equity Group
   7577 Calle Facil
   Sarasota, FL 34238

   Or, fax to 864-242-0698
   Or, email to:
   mailbox@regroupusa.com

OR, Enroll ONLINE

www.benefitssitedemo.com

QUESTIONS:
Call 800-527-1397

ENROLLMENT

Companion Life
Resource Equity Group, Agent/Admin.
7577 Calle Facil, Sarasota, FL 34238 | 800-527-1397
Email: mailbox@regroupusa.com

Select desired coverage(s) below:

☐ **LIFE INSURANCE**:
Employee: Amount $______________
Spouse: Amount $______________
Children: Amount $______________

☐ **LONG TERM DISABILITY**
Monthly benefit: 60% of salary

☐ **SHORT TERM DISABILITY**
Weekly benefit amount: $___________

☐ **DENTAL INSURANCE:**
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Employee & Family

☐ **VISION CARE:**
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Children
- ☐ Employee & Family

I elect to participate in the "Your Company"Benefits Plan, and authorize "Your Company" to adjust my compensation as necessary to pay my share of the cost for the employee benefit plans, in accordance with the terms of the Plan. This election takes effect on the effective date and on the plan anniversaries which coincides with the next following plans years.

EMPLOYEE:____

Email address:______________________________________

SIGNED X____

DATE____

GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life

Companion Life Insurance Company
P.O. Box 1535 • Dubuque, IA 52004-2535
877-676-5789 (Phone) • 563-557-3350 (Fax)

☐ New Employee ☐ Add/Increase Coverage ☐ Change Beneficiary ☐ COBRA
☐ Change Address ☐ Change Dependent Coverage ☐ Change Class or Status ☐ Terminate Coverage

Companion Use Only
Approved: ☐ Declined: ☐
Date: ____________________
By: ____________________

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

TO BE COMPLETED BY EMPLOYEES

Social Security Number	Effective Date	Date Employed Full-time	Date of Birth	Hours Worked Per Week
	Month / Day / Year	Month / Day / Year	Month / Day / Year	

Your Name	Sex	Earnings
Last First M.I.	☐ Female ☐ Male	☐ Weekly ☐ Monthly ☐ Annually Earnings $ ____________ * *Do not include overtime or bonuses*

Marital Status	Occupation	Your Home Address
☐ Single ☐ Married		Street Apt/Suite No. City State ZIP Code

COMPLETE FOR LIFE AND/OR DISABILITY

COVERAGE REQUESTED ☐ Basic Life ☐ AD&D ☐ Dependent Life ☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary Life ☐ Voluntary Long Term Disability

COMPLETE FOR VOLUNTARY LIFE

Amount Selected: **Voluntary Life** EMPLOYEE: $ ______ **Voluntary Life** SPOUSE: $ ______ **Voluntary Life** CHILD: $ ______

Spouse Name: *(Voluntary Life Only)* Last / First / M.I.	Birthdate (M/D/Y)	Social Security Number

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for dependent coverage) (Applies to Life, Disability and Critical Illness)*
Last First M.I. Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION AND/OR CRITICAL ILLNESS

Coverage Requested: ☐ Dental - Employee Only ☐ Dental - Employee & Dependents ☐ Vision - Employee Only ☐ Vision - Employee & Dependents ☐ Critical Illness - Employee Only ☐ Critical Illness - Employee & Dependents

Is your spouse to be covered?	Dental and/or Vision Coverage Is For (Check Box Below):				Are you or any of your dependents covered for dental insurance under another policy?
☐ **Yes** ☐ **No**	☐ Employee	☐ Employee plus Spouse	☐ Employee plus Child(ren)	☐ Family	☐ Yes ☐ No

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):

☐ Basic Life ☐ AD&D ☐ Dependent Life ☐ Short Term Disability ☐ Long Term Disability ☐ Dental ☐ Vision ☐ Critical Illness ☐ Voluntary Life ☐ Voluntary Long Term Disability ☐ Voluntary Dental

Date	Your Signature
	X

See Pages Two and Three for Companion Life Form 95734 for Fraud Notices

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.