

Mailing Address:
 P.O.Box 100102 Columbia, South Carolina 29202 • (803)735-1251

**Companion Life
 Insurance Company**

**Group Insurance
 Implementation Form**

GROUP INFORMATION

Full Legal Name of the Group: _____ Effective Date: _____

This form is designed to provide Companion Life Insurance Company the information needed to set up your group benefit plan(s). Please complete this document in its entirety and provide all required information to Companion Life Insurance Company no later than 10 business days prior to your effective date. We will review your application along with the proposed plans. If any material changes are requested, Companion Life Insurance Company reserves the right to re-evaluate the proposed plans and rates.

Please check all that apply:

New Group Change current Coverage(s) Add new Coverage to an in force Group, please provide Group number: _____

Defined Contribution Plan (DCP) Add new location/division to an in force Group, please provide Group number: _____

Are there any classes that are excluded from coverage? Yes No If Yes, please specify the class (hourly, salary, part-time, etc.) or division and the coverage(s) from which they are excluded.

EARNINGS DEFINITION

What is the definition of compensation for benefits based on salary? *(Basic Life, Voluntary Term Life, Short-Term & Long-Term Disability)*

Base wage (excludes bonus, commissions, overtime)

Base wage with bonus *

Base wage with commission *

Base wage with bonus and commission *

* For bonus / commission earnings, select the month average: 12 months 24 months 36 months

ELECTRONIC DATA INTERCHANGE (EDI) INFORMATION

Is there a need to setup an Electronic Data Interchange (EDI)? *(minimum of 25 lives required)*

Yes No If Yes, please provide vendor info below:

EDI Vendor Name: _____	Email address: _____
EDI Contact Name: _____	Phone: _____

GROUP CONTACT INFORMATION

Group Administrator Information:	Billing Contact Information:
Name: _____	Name: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

BILLING AND LOCATION INFORMATION

List Bill: Companion Life provides a monthly invoice including benefit amounts and premium due shown at the enrollee level.

Self-Administered Bill: Group generates required monthly report (pre-approval required).

Third-Party Administrator (TPA) bill: TPA to manage your billing and remittance. Provide TPA information below.

<i>Please check one of the three options below:</i>		<i>Select the below for List Bill Options:</i>
List Bill	<input type="radio"/> Receive monthly invoice from Companion Life Insurance Company	<input type="radio"/> One Bill with no segmentation <input type="radio"/> One Bill with Subtotals by Location/Division <input type="radio"/> Separate Bills for Each Location/Division
Self-Administered Bill	<input type="radio"/> Submit required monthly reporting to Companion Life Insurance Company	Self-Administered Bill agreement required.
Third-Party Administered (TPA) (Preapproval from Companion Life required)	<i>If you have a Third-Party Administrator (TPA) to manage your billing and remittance, please provide TPA information below:</i>	
	<input type="radio"/> TPA Name: _____	TPA Contact: _____
	Address: _____	Email: _____
	City/State/Zip: _____	Phone Number: _____

List Bill:	
If you select One Bill with Subtotals by Location/Division OR Separate Bills by Location/Division , please complete the below: <i>If more space is needed, please attach additional pages.</i>	Number of Locations/Divisions: _____

1.	Location/Division Name: _____ <input type="checkbox"/> Same address as Group Headquarters Address: _____ City/State/Zip: _____	Billing Contact: _____ Phone Number: _____ Email Address: _____	
2.	Location/Division Name: _____ <input type="checkbox"/> Same address as Group Headquarters Address: _____ City/State/Zip: _____	Billing Contact: _____ Phone Number: _____ Email Address: _____	
3.	Location/Division Name: _____ <input type="checkbox"/> Same address as Group Headquarters Address: _____ City/State/Zip: _____	Billing Contact: _____ Phone Number: _____ Email Address: _____	
4.	Location/Division Name: _____ <input type="checkbox"/> Same address as Group Headquarters Address: _____ City/State/Zip: _____	Billing Contact: _____ Phone Number: _____ Email Address: _____	
5.	Location/Division Name: _____ <input type="checkbox"/> Same address as Group Headquarters Address: _____ City/State/Zip: _____	Billing Contact: _____ Phone Number: _____ Email Address: _____	
6.	Location/Division Name: _____ <input type="checkbox"/> Same address as Group Headquarters Address: _____ City/State/Zip: _____	Billing Contact: _____ Phone Number: _____ Email Address: _____	

ELIGIBILITY AND COVERAGE INFORMATION

Eligibility Rules:

Waiting Period – Amount of time before an enrollee is eligible for coverage

Waiting Period

Current eligible enrollees are to be covered:	Enrollees hired after the plan effective date are to be covered:
<input type="radio"/> Immediately on the requested effective date. <input type="radio"/> After _____ days. <input type="radio"/> 1 st of the month following _____ days. <input type="radio"/> 15 th of the month following _____ days. <input type="radio"/> Other: _____	<input type="radio"/> Immediately on the date of hire. <input type="radio"/> After _____ days. <input type="radio"/> 1 st of the month following _____ days. <input type="radio"/> 15 th of the month following _____ days. <input type="radio"/> Other: _____

Process enrollee terminations for: End of the month Date of termination Other _____

Elected Coverages	Benefit Taxation	Other Info	Group Contribution %
<input type="checkbox"/> Basic Life			
<input type="checkbox"/> Basic Life w/AD&D			
<input type="checkbox"/> Basic Dependent Life			
<input type="checkbox"/> Basic Dependent Life w/AD&D			
<input type="checkbox"/> Voluntary Life		Spouse rates are calculated by: <input type="radio"/> Spouse age <input type="radio"/> Employee age	0%
<input type="checkbox"/> Voluntary Life w/AD&D			0%
<input type="checkbox"/> Voluntary Dependent Life		<input type="radio"/> Spouse <input type="radio"/> Child	0%
<input type="checkbox"/> Voluntary Dependent Life w/AD&D		<input type="radio"/> Spouse <input type="radio"/> Child	0%
<input type="checkbox"/> Short-Term Disability	Are benefits taxable? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gross-Up	
<input type="checkbox"/> Voluntary Short-Term Disability	Are benefits taxable? <input type="checkbox"/> Yes <input type="checkbox"/> No		0%
<input type="checkbox"/> Long-Term Disability	Are benefits taxable? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gross-Up	
<input type="checkbox"/> Voluntary Long-Term Disability	Are benefits taxable? <input type="checkbox"/> Yes <input type="checkbox"/> No		0%
<input type="checkbox"/> Dental		<input type="radio"/> Calendar Year Benefit <input type="radio"/> Contract Year Benefit	
<input type="checkbox"/> Vision			
<input type="checkbox"/> Accident			
<input type="checkbox"/> Critical Illness			
<input type="checkbox"/> GAP			
<input type="checkbox"/> Hospital Indemnity & Limited Benefit Medical Plan			

**Contribution – if contribution varies by class or benefit option, please explain below:*

W-2 SERVICE OPTIONS FOR STD AND LTD: (pre-approval required)

<input type="checkbox"/> Option 1: No Services		
<input type="checkbox"/> Option 2: W-2 Tax Reporting Services Only (no FICA Employer Match Service; weekly reporting provided)	<input type="radio"/> STD	Automatically included for LTD
<input type="checkbox"/> Option 3: W-2 Tax Reporting Services and FICA Match Service	<input type="radio"/> STD	<input type="radio"/> LTD

If Option 2 or 3 is chosen, Group appoints Companion Life, or its assignee, as its agent to handle tax withholdings. If Option 3 is chosen, Group appoints Companion Life or its assignee, as its agent to make W-2 Form filings.

The W-2 service is only available if it was included in the proposal.

ONLINE PORTAL ACCESS REQUEST

MyOnlineBenefit.com is a secure online benefit administration tool designed to help groups work with us more efficiently.

Capabilities Available with MyOnlineBenefit

View Only Access

- View bill summary and billing detail
- View bill and payment history
- View group policies
- View insured enrollees' certificates
- View summary of benefits

Full Access

- Add/change insured enrollees
- Add/change insured enrollees' coverage
- Add/change dependents
- Terminate insured enrollees
- View Access also included with this feature

Group Contacts

Please provide the contact information requested below and check the appropriate box for the level of access you are requesting.

- 1) Contact Name: View Only Access Full Access
Phone Number (including Area Code):
Email Address:
- 2) Contact Name: View Only Access Full Access
Phone Number (including Area Code):
Email Address:

If you would like your agent's office to also have access to your group's information via MyOnlineBenefit.com, please provide the contact information requested below and check the appropriate box for the level of access they should be given.

Agent / Agency Contacts

- 1) Contact Name: View Only Access Full Access
Phone Number (including Area Code):
Email Address:
- 2) Contact Name: View Only Access Full Access
Phone Number (including Area Code):
Email Address:

PLEASE READ CAREFULLY

The Policy and Certificate forms will be delivered to the group electronically.

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 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, if any. Only Companion Life's Home Office has the authority to guarantee the acceptability of the requested insurance.

GROUP SIGNATURE

Signature:	_____		
Printed Name:	_____		
Title:	_____	Phone Number:	_____
City / State:	_____	Email Address:	_____
Date:	_____		

AGENT / BROKER INFORMATION

Have you explained to the Group that an Individual not actively at work on the policy effective date will not be covered until such Individual returns to active work full time unless approved in writing by an underwriter or officer of Companion Life? Yes No

Pay commissions to: <input type="checkbox"/> Agent <input type="checkbox"/> Agency	Email Address: _____
	Telephone Number: _____
Writing Agent Name: _____	NPN: _____
Legal Agency Name (if applicable): _____	Tax ID: _____
Mailing Address: _____	
Agency Mailing Address (use only when Agency is paid directly): _____	
City / State / Zip: _____	
General Agency Name (if applicable): _____	NPN: _____

Commission Scale

Plan of Insurance	Flat	Graded	Plan of Insurance	Flat	Graded
Basic Life / AD&D _____ %	<input type="checkbox"/>	<input type="checkbox"/>	Dental _____ %	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Life / AD&D _____ %	<input type="checkbox"/>	<input type="checkbox"/>	Vision _____ %	<input type="checkbox"/>	<input type="checkbox"/>
Short-Term Disability _____ %	<input type="checkbox"/>	<input type="checkbox"/>	Accident _____ %	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Short-Term Disability _____ %	<input type="checkbox"/>	<input type="checkbox"/>	Critical Illness _____ %	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Disability _____ %	<input type="checkbox"/>	<input type="checkbox"/>	Hospital Indemnity / LBMP _____ %	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Long-Term Disability _____ %	<input type="checkbox"/>	<input type="checkbox"/>			

Special Instructions for group set up:

AGENT / BROKER SIGNATURE

By signing below, I attest that I am licensed in the state of this group for the types of insurance solicited.

_____	_____
Signature of Agent / Broker	Date

Name of Agent / Broker (Print)	