dental by design®

Dental by Design Program

Please Print or Type (Defined Contribution Plans)

EMPLOYER INFORMATION

1. Full legal name of applicant (As it should appear in policy) Telephone Number

2. Applicant's Federal Tax ID Number

3. Address Street Post Office Box ZIP

City County State ZIP

4. Administrative Correspondence with the Applicant should be addressed to:
   Name Title

5. Nature of Business

6. Requested Effective Date:

7. Are there subsidiary businesses covered under this plan? If YES, please state name and nature of each subsidiary or affiliate.
   ☐ Yes ☐ No

   Are separate billings required? If YES, please provide billing instructions.
   ☐ Yes ☐ No

8. Type of Administration: ☐ Home Office Administered ☐ Self Administered

EMPLOYEE ELIGIBILITY

The normal work week for full-time employees must be at least 30 hours unless otherwise approved by Companion Life.

9. Current eligible employees are to be covered:
   ☐ Immediately on the requested effective date.
   ☐ After _____ days of continuous employment.
   ☐ First of the month following ____ days of continuous employment.

10. Employees hired after the plan effective dates are to be covered:
   ☐ Immediately.
   ☐ After _____ days of continuous employment.
   ☐ First of the month following ____ days of continuous employment.

Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.

11. Number of Eligible Employees: _____

12. Number of Enrolled Employees: _____

SPECIFICATIONS FOR INSURANCE

13. Defined Contribution:
   Please select one option: ◯ $15 ◯ $30 ◯ $50

14. Will this coverage replace any existing dental insurance plan? If YES, name existing insurance carrier:
   ☐ Yes ☐ No

15. Existing Plan Effective Date:

16. Termination Date of Existing Plan

17. Check coverages being replaced:
   ☐ Preventive ☐ Basic ☐ Major ☐ Orthodontia

18. Is prior insurance credit (takeover benefits) requested? ☐ Yes ☐ No

19. The following documentation is required when prior insurance credit is requested. Your current dental plan must have been in effect continuously for at least 12 months prior to effective date.
   - Evidence that the prior carrier's coverage has been in force for at least 12 months.
   - A copy of the most recent bill that includes a listing of all covered employees and their effective dates of coverage (Standard Takeover only).
   - A copy of the in-force dental plan that may be a contract, certificate or booklet.

COMPANION LIFE (Defined Contribution Plans)

20. SELECT OPTIONS	☐ Option 1 Modified Select	☐ Option 2 Modified Select	☐ Option 3 Modified Essentials	☐ Option 4 Modified Essentials
Program Deductible Per Individual Family Limit	$50 Contract Year 3	$50 Contract Year 3	$100 Lifetime No Limit	$100 Lifetime No Limit
Waived for Type I Service?	Yes	Yes	No	No
Type I Preventive Services	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)
Type II Basic Services	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics	80% space maintainers, fillings, pain treatment, sealants, full mouth X-rays	80% space maintainers, fillings, pain treatment, sealants, full mouth X-rays
Benefit Waiting Period	None	None	None	None
Type III Major Services	50% crowns, inlays, onlays, dentures, bridges, implants	50% crowns, inlays, onlays, dentures, bridges, implants	50% anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants	25% anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants
Benefit Waiting Period	12 months	12 months	12 months	12 months
Contract Year	$2,000	$1,000	$1,000	$500
Type IV Orthodontia Child(ren) Only Lifetime Maximum Deductible Benefit Waiting Period	50% Child(ren) Only $2,000 None 12 months	50% Child(ren) Only $1,000 None 12 months	50% Child(ren) Only $1,000 None 12 months	0% *Not Available*
Orthodontia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Takeover Benefit	○ Preferred* ○ Not Available	○ Preferred* ○ Not Available	○ Preferred* ○ Not Available	○ Preferred* ○ Not Available

**Preferred Takeover — The waiting period(s) for existing employees, including those who weren't on the prior plan, will be waived. The prior dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. All waiting periods will apply to future new employees.*

Disclaimer: This is a summary of benefits only. Please refer to the policy for comprehensive benefit details. Payment is based upon allowable charges in the area in which service is rendered. Any dentist charge above the allowable charge is not a covered expense.

COMPANION LIFE **MAC PPO PLAN** (Defined Contribution Plans)

21. SELECT OPTIONS	☐ Option 1 Modified Select	☐ Option 2 Modified Select	☐ Option 3 Modified Essentials	☐ Option 4 Modified Essentials
Program Deductible Per Individual Family Limit	$50 Contract Year 3	$50 Contract Year 3	$100 Lifetime No Limit	$100 Lifetime No Limit
Waived for Type I Service?	Yes	Yes	No	No
Type I Preventive Services	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months), space maintainers, pain treatment, sealants, full mouth X-rays	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)	100% oral exams, cleanings (2 per 12 months), bitewing X-rays (1 per 12 months)
Type II Basic Services	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics	80% fillings, anesthesia, simple & surgical extractions, endodontics, oral surgery, periodontics	80% space maintainers, fillings, pain treatment, sealants, full mouth X-rays	80% space maintainers, fillings, pain treatment, sealants, full mouth X-rays
Benefit Waiting Period	None	None	None	None
Type III Major Services	50% crowns, inlays, onlays, dentures, bridges, implants	50% crowns, inlays, onlays, dentures, bridges, implants	50% anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants	25% anesthesia, endodontics, simple & surgical extractions, oral surgery, periodontics, crowns, inlays, onlays, dentures, bridges, implants
Benefit Waiting Period	12 months	12 months	12 months	12 months
Contract Year	$2,000	$1,000	$1,000	$500
Type IV Orthodontia Child(ren) Only Lifetime Maximum Deductible Benefit Waiting Period	50% Child(ren) Only $2,000 None 12 months	50% Child(ren) Only $1,000 None 12 months	50% Child(ren) Only $1,000 None 12 months	0% *Not Available*
Orthodontia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Takeover Benefit	◯ Preferred* ◯ Not Available	◯ Preferred* ◯ Not Available	◯ Preferred* ◯ Not Available	◯ Preferred* ◯ Not Available

This Dental Plan is a Maximum Allowable Charge (MAC) Plan This program uses DenteMax contracted providers as a Preferred Provider Network. The MAC Plan's maximum allowable charges (MAC) for al covered dental procedures are the DenteMax discounted fees, which are paid to both in- and out-of-network providers. If a patient sees an in-network DenteMax dentist for a covered procedure, the patient is responsible only for the applicable coinsurance and deductible. There is no balance billing; if a patient sees a non-network dentist, Companion Life will reimburse based upon the DenteMax/MAC fee, and the dentist may charge the patient the difference between his/her own fee and the DenteMax/MAC fee.

**Preferred Takeover — The waiting period(s) for existing employees, including those who weren't on the prior plan, will be waived. The prior dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. All waiting periods will apply to future new employees.*

Disclaimer: This is a summary of benefits only. Please refer to the policy for comprehensive benefit details. Payment is based upon allowable charges in the area in which service is rendered. Any dentist charge above the allowable charge is not a covered expense.

EMPLOYER'S SIGNATURE

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): 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 thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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.

Dated at _____ (City/State) this _____ day of _____, 20 _____

_____ Signature of Employer

_____ Title

_____ Witness

AGENT'S REPORT

22. Initial Deposit (Minimum first month's premium is required.)
    $

23. Agent/Broker Name (Please Print) Telephone Number

24. Address

    City County State Zip

25. Agent/Broker E-mail Address:

26. Are there other group insurance plans that duplicate 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 purposes of these plans:

27. Is Agent or Broker licensed and appointed by Companion for the types of insurance solicited where this group is located?
    ☐ Yes ☐ No Agent Code Number _____ State License_____

28. Signature of Agent/Broker _____ Date _____

Companion Life

CompanionLife.com

SERVICE
QUALITY
FLEXIBILITY
COMMITMENT

www.CompanionLife.com

GROUP APPLICATION

(Defined Contribution Plans)

Companion Life

Companion Life Insurance Company
P.O. Box 100102
Columbia, SC 29202-3102

PHONE
800-753-0404

APPLICATION FOR GROUP LIFE, AD&D, SHORT TERM DISABILITY AND LONG TERM DISABILITY (Defined Contribution Plans)

EMPLOYER INFORMATION

1. FULL LEGAL NAME OF EMPLOYER (as it should appear in policy): _____ Telephone Number: ( ) _____ (Area Code)
   Full Years in Business: _____
2. EMPLOYER'S FEDERAL TAX ID NUMBER: _____ Email Address: _____
   Type of Business: _____ (i.e.,: Partnership, Sole Proprietorship, Corporation, etc.)
3. ADDRESS Street: _____ Post Office Box: _____ ZIP: _____
   City: _____ County: _____ State: _____ ZIP: _____
4. ADMINISTRATIVE CORRESPONDENCE with the applicant should be addressed to:
   Name: _____ Title: _____
5. NATURE OF BUSINESS: _____
6. REQUESTED EFFECTIVE DATE (12:01 a.m.): _____ , 20 _____
7. PREMIUMS ARE TO BE PAID MONTHLY.
8. Are there subsidiary or affiliate businesses covered under this plan? ☐ Yes ☐ No
   If YES, please state name and nature of each subsidiary or affiliate: _____
   Are separate billings required? ☐ Yes ☐ No If YES, please provide billing instructions: _____
9. Type of Administration: ☐ Home Office administered ☐ Group Administered (minimum 250 lives) ☐ MGU/TPA/GBA Administered
10. Will the requested insurance replace existing insurance? ☐ Yes ☐ No If YES, give coverage, name of existing carrier and proposed termination date: _____

EMPLOYEE ELIGIBILITY

11. The normal work week for full-time employees is _____hours.
    Eligibility: All regular full-time employees working a minimum of _____hours per week.
    (The minimum work week for full-time employees to be eligible for benefits is 30 hours. Employees working fewer than 30 hours per week may be acceptable; contact Companion Life for approval.)
12. Current eligible employees are to be covered:
    - ☐ Immediately on the requested effective date.
    - ☐ After _____ days of continuous employment.
    - ☐ First of the month following _____ days of continuous employment.
13. Current eligible employees are to be covered immediately.
14. Employees hired after the plan effective date are to be covered:
    - ☐ Immediately.
    - ☐ After _____ days of continuous employment.
    - ☐ First of the month following _____ days of continuous employment.
    - ☐ LTD (minimum of 60 days): _____
15. Number of Eligible Employees: _____
16. Number of Enrolled Employees: _____
17. Number of family members in firm (no more than 50%): _____
18. 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
☐ All Full-Time Employees ☐ Other _____ _____	☐ $25,000 ☐ $50,000 ☐ Other _____ _____	Benefit Period ☐ 8-8-13 ☐ 8-8-26 ☐ 15-15-52 Weekly Benefit Max. $1,250 Benefit Amount: 60%	Elimination Period ☐ 90 Days ☐ 180 Days Pre-ex: _____ Benefit Amount: 60%
Percentage of Premium Paid	(n/a)	☐ 0% (Post-Tax) - not taxable ☐ 100% (Pre-Tax) - taxable	(n/a)
Defined Contribution Amount	Please select one: ○ $15 ○ $30 ○ $50		

SPECIFICATIONS FOR INSURANCE

19. Are there any ineligible classes or divisions? ☐ Yes ☐ No If YES, please describe:_____

_____

20. Are any eligible employees disabled at this time? ☐ Yes ☐ No If YES, please describe: _____

_____

21. Is a Section 125 Plan in effect? ☐ Yes ☐ No

If yes, please indicate which Companion Life Benefits will be subject to the Section 125 Plan and note the employer's and employee's contributions.

☐ Life & AD&D	☐ STD	☐ LTD	☐ Voluntary Life
ER_____%	ER_____%	ER_____%	ER_____%
EE_____%	EE_____%	EE_____%	EE_____%

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

☑ 35% at age 65, 50% at age 70 and then 75% at age 75. Benefits terminate when employee is no longer actively at work.

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

24. DEPENDENT LIFE BENEFITS ☐ Yes ☐ No

A. Spouse Amount: ☐ $5,000
B. Maximum Child Amount: ☐ 14 Days to 6 Months $100 ☐ 6 Months and over $5,000
C. Coverage for children continues until age 26.

25. SHORT TERM DISABILITY (STD) BENEFITS ☐ Yes ☐ No (Excludes occupational injury or sickness)

Includes maternity. 12/12 pre-ex included.

26. TRUE GROUP LONG TERM DISABILITY BENEFITS ☐ Yes ☐ No

A. Maximum Monthly Benefit: ☐ 10-24 eligible lives: up to $3,000 per month ☐ 25-99 eligible lives: up to $5,000 per month
B. Maximum Benefit period will be: ☐ SSNRA (Reducing Benefit Duration ☐ 5 Years ☐ 2 Years)
C. Minimum Monthly Benefit: add $100 minimum or 10% LTD Benefits
D. Own Occupation Definition is 2 Years
E. Benefit Integration: Primary and Family Social Security (Standard)
F. Pre-Existing Condition Limitations: Standard: 12/6/24 (12/12 in MD and SC, 3/12 in PA).

27. SPECIAL REQUESTS/INSTRUCTIONS:_____

_____

_____

EMPLOYER'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 Employer) (Title) (Witness)

AGENT'S REPORT

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

29. Are all the employees to be insured for Disability Income covered by Workers' Compensation? ☐ Yes ☐ No
If NO, explain: _____

30. 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: _____

31. Is there another group insurance plan(s) that 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(s) of this plan(s): _____

_____

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

33. To the best of the Agent's or Broker's knowledge, replacement ☐ is ☐ is not involved with this transaction.

34. Print name of Agent/Broker _____

35. Signature of Agent/Broker _____ Date _____

FRAUD WARNING (Not Applicable in AZ, FL, MD, OR, VA): 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 thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Companion Life

P.O. Box 100102
Columbia, SC 29202-3102

VOLUNTARY GROUP TERM LIFE INSURANCE EMPLOYER PARTICIPATION APPLICATION

(Defined Contribution Plans)

The undersigned Employer applies for membership in the Companion Life Joint Employer Group Insurance Trust and for participation in the insurance coverage now in effect or later modified.

1. Legal Name of Employer

2. Group Number

3. Address

4. Name of Subsidiaries, Divisions or Affiliates to be covered

5. Name of Contact

6. Telephone Number

7. Proposed Effective Date 12:01 A.M.

8. Nature of Business

9. Number of Employees
   Eligible _____ Enrolled _____

10. Are any employees disabled at this time? ☐ Yes ☐ No If yes, give details. Use additional sheet, if required.
    _____

11. Is there any other insurance in force, being applied for or being issued at this time? ☐ Yes ☐ No
    If yes, give details: _____
    Is this insurance intended to replace any existing group life insurance? ☐ Yes ☐ No If yes, give details
    (company name, coverage termination date) _____

12. Eligibility
    All regular full-time employees working a minimum of _____ hours per week (not less than 30 hours per week).
    Are any employees excluded from coverage? ☐ Yes ☐ No
    If yes, please define: _____

13. Current eligible employees are to be covered:
    - ☐ Immediately on the requested effective date.
    - ☐ After _____ days of continuous employment.
    - ☐ First of the month following ____ days of continuous employment.

14. Employees hired after the plan effective dates are to be covered:
    - ☐ Immediately.
    - ☐ After _____ days of continuous employment.
    - ☐ First of the month following ____ days of continuous employment.

15. Guaranteed Issue Based on Eligible Employees

    Guaranteed Issue Employee: $100,000 (up to age 65). Guaranteed Issue Spouse: $50,000 (max. benefit of 50% of employee benefit).

16. Amount of Insurance: Employee

    ☐ **Companion Choice Plus Employee Life Insurance:**
    Option of $25,000 up to $250,000 in $25,000 increments.

    ☐ **Accidental Death and Dismemberment Insurance:**
    (The AD&D amount will be the same as the Life Insurance amount. The AD&D is not available for children.)

17. Dependent Benefits:

    ☐ **Spouse Life Insurance:**
    $12,500 increments, not to exceed 50% of the employee amount.

    ☐ **Dependent Life Insurance:**
    6 months to age 26.
    14 days to 6 months. ($100 benefit)
    Option of $2,500, $5,000, $7,500 or $10,000 (Employee coverage required).

18. Defined Contribution:
    Please select one option: ○ $15 ○ $30 ○ $50

19. Reduction:

    Employee and spouse Life Insurance benefit reduces to 65% at the individual's age 65, reduces to 50% of the original amount at age 70, to 35% at age 75, to 20% at age 80, and terminates at the employee's retirement, whichever occurs first.

    The Dependent Child benefits terminate upon termination of the employee's benefit.

EMPLOYER PARTICIPATION AGREEMENT
Administered and Underwritten by Companion Life Insurance Company

The Participating Employer does hereby apply for Voluntary Group Term Life Insurance as set forth in this request and subscribes to the Agreement and Declaration of Trust.

NAME OF TRUST: Joint Employer Group Insurance Trust

It is understood and agreed that all the following requirements shall be met:

1. The insurance shall not become effective unless this request is accepted and approved by the Administrator.
2. The Participating Employer will furnish and maintain the records necessary to the Administration of the Plan, will report changes to and from the group, will process claims promptly as they occur, and will make all premium payments in accordance with the terms of the Plan.
3. I understand that only permanent active employees, partners, and proprietors working the minimum hours shown on the Participation Agreement are eligible for coverage. I understand the Guarantee Issue limitation of the insurance plan and understand that the coverage is renewable at the option of the Underwriting Company.
4. I understand the underwriting and participation requirements, and understand that the initial participation (if applicable) must be maintained or exceeded in order for coverage to remain in force.
5. Insurance coverage on any individual shall become effective on the first premium due date coinciding with, or next following, satisfaction of any waiting period and receipt and approval of proper enrollment material (including evidence of insurability, if required).
6. Any Employer or Member contributions will be collected by the Participating Employer. The Participating Employer agrees to remit these premiums on or before each premium due date to the Administrator or to its designated representative.
7. Premium rates for an insured will increase on the policyholder's next anniversary following the date the insured enters the next age bracket. In addition, Companion Life reviews premiums annually and rates are subject to change.

The Participating Employer acknowledges and warrants that coverage under any policy through the Joint Employer Group Insurance Trust shall only be as and to the extent provided in the insurance policy or policies held by the Trustee, and the Participating Employer has explained this to each person for whom it seeks benefits thereunder, and the Participating Employer further acknowledges and agrees that, notwithstanding the date of this application or the date when the Administrator may act hereon, coverage will commence only if this application is accepted by the Administrator and then only upon the effective date to be inserted by the Administrator in the acceptance form below. The Participating Employer further acknowledges and agrees that no one other than an executive officer of the Administrator or other person designated by the Administrator in writing to do so and acting at the Administrator's Office in Columbia, South Carolina, may accept this application on behalf of the Joint Employer Group Insurance Trust.

The Participating Employer may withdraw from the Joint Employer Group Insurance Trust and cancel its application at any time upon thirty-one (31) days' prior written notice to the Administrator. Failure to remit and pay charges when due shall automatically constitute such withdrawal and cancellation of all coverage. In the event coverage is terminated because of non-payment of premium and the Participating Employer has not given thirty-one (31) days' written notice of such desire to cancel coverage, the Participating Employer shall be liable for all premiums that fall due for coverage provided during the thirty-one (31) day grace period following the last premium due date.

It is understood and agreed by the undersigned that the Trustee is not an insurer, and does not 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 Company 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 Participating Employer at the office of the Administrator, located at 7909 Parklane Road, Suite 200, Columbia, South Carolina. The Administrator may cancel the Participating Employer's application and membership in the Joint Employer Group Insurance Trust at any time upon 45 days' prior written notice to the Participating Employer.

The Participating Employer does herewith remit the sum of $_____ on account of the first premium or the first and subsequent premiums on a policy of group insurance for which request has been made to Companion Life Insurance Company. If such Participating Employer is not approved or if for any reason the insurance applied for does not become effective, the amount paid in exchange for this receipt shall be refunded.

FRAUD WARNING: (not applicable in AZ, FL, MD, OR, VA): 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 thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING: (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

_____ (Company)

By: _____

_____
(Title) (Date)

_____
Agent Name (Please print or type)

Accepted by Administrator

By: _____

_____
(Title) (Date)

Effective Date: _____

VISION EMPLOYER PARTICIPATION APPLICATION FOR THE JOINT EMPLOYER GROUP INSURANCE TRUST

visionbydesign

Companion Life Insurance Company • PO Box 100102 • Columbia, South Carolina 29202-3102

FAX (803) 735-0736
1-800-753-0404

Please Print or Type

EMPLOYER INFORMATION

1. Full legal name of applicant (As it should appear in policy) Telephone Number ( )

2. Applicant's Federal Tax ID Number

3. Address Street Post Office Box

City County State Zip

4. Administrative Correspondence with the Applicant should be addressed to:
   Name _____ Title _____
   Fax Number _____ E-mail Address _____

5. Nature of Business

6. Requested Effective Date:

7. Are there subsidiary businesses covered under this plan? If YES, please state name and nature of each subsidiary or affiliate.
   ☐ Yes ☐ No

   Are separate billings required? If YES, please provide billing instructions.
   ☐ Yes ☐ No

8. Type of Administration: ☐ Home Office Administered ☐ Self Administered

EMPLOYEE ELIGIBILITY

9. The normal work week for full-time employees is:____ hours. The normal work week for full-time employees must be at least 30 hours. Employees working less than 30 hours per week may be acceptable. Contact Companion Life for approval.

10. Current eligible employees are to be covered:
   ☐ Immediately on the requested effective date.
   ☐ After _____ days of continuous employment.
   ☐ First of the month following ____ days of continuous employment.

11. Employees hired after the plan effective dates are to be covered:
   ☐ Immediately.
   ☐ After _____ days of continuous employment.
   ☐ First of the month following ____ days of continuous employment.

12. Coverage following completion of the waiting period selected will be effective the first of the month following completion of the waiting period or the next billing date.

SPECIFICATIONS FOR INSURANCE

13. Will this coverage replace any existing vision insurance plan? If YES, name present insurance carrier:
   ☐ Yes ☐ No

14. Existing Plan Effective Date:

15. Termination Date of Existing Plan

Select Your visionbydesign Program on the reverse side.

16. **Choose Benefit Design and Options** (Required)

☐ Vision Essentials Plan (Exam Only + Discount)	☐ Vision Choice Plan (Eyewear Only + Discount)	☐ Vision Select Plan (Exam + Eyewear + Discount)
Exam Copay: ☐ $0 ☐ $10 ☐ $20 Exam Frequency: 12 months	N/A	Exam/Lens Copays: ☐ $0/0 ☐ $10/$10 ☐ $20/$20 Exam Frequency: 12 months
N/A	Eyewear Allowances: ☐ $100 Frame/$115 Contacts ☐ $130 Frame/$130 Contacts Frames Frequency: ☐ 12 months ☐ 24 months Lens/Contact Lens Frequency: 12 months	Eyewear Allowances: ☐ $100 Frame/$80 Contacts ☐ $130 Frame/$120 Contacts Frames Frequency: ☐ 12 months ☐ 24 months Lens/Contact Frequency: 12 months

17. **Choose Premium Rate Structure** (Required) ☐ Two Tier ☐ Three Tier ☐ Four Tier
(If sold with Dental, Vision and Dental must have the same premium rate structure)

18. Number of Eligible Employees: _____ 19. Number of Enrolled Employees: _____

20. Percent of Premium Paid by Employer: ☐ Single/Employee Only _____% ☐ Family/Dependents _____%

21. **Special Vision Product Pricing:** If employee contributions are involved, Companion Life offers special Vision Plan premium rates for employer groups offering a Companion Life Vision plan along with a Companion Life Group Dental Insurance plan. To qualify for these special Vision Plan rates, 100% of those enrolled in the Group Dental plan must also participate in the Vision plan.

a. Will employees contribute to the cost of the Vision plan? ☐ Yes ☐ No

b. Will this Vision Plan be enrolled with a Companion Group Dental Insurance plan? ☐ Yes ☐ No

c. If yes, will 100% of the employees and dependents enrolled in the Companion Life Group Dental plan be required to take the Vision Plan? ☐ Yes ☐ No

FRAUD WARNING (Not applicable in AZ, FL, MD, OR, VA): 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 thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL ONLY): Any person who knowingly and with intent to injure, defraud or decieve any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Participation Agreement (Administered and underwritten by Companion Life Insurance Company)

The Employer hereby applies for Group Insurance Benefits as set forth in the above "Vision by Design" Employer Participation Application for the Joint Employer Group Insurance Trust and subscribes to the Agreement and Declaration of Trust.

Name of Trust: The Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee have any obligation under any policy of insurance and that all claims for the 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(ies). 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.

_____
(Signature of Employer/Applicant))

_____
(Title) (Date)

_____
(Signature of Resident Agent/Broker))

_____
Print Agent's/Broker's Name License No.

HOME OFFICE USE ONLY Employer Group No.:_____

Accepted by Companion Life Effective: _____

By: _____
(Title) (Date)